RHODE ISLAND STATE HEALTHCARE INNOVATION PLAN

Better Health, Better Care, Lower Cost

ACKNOWLEDGMENTS

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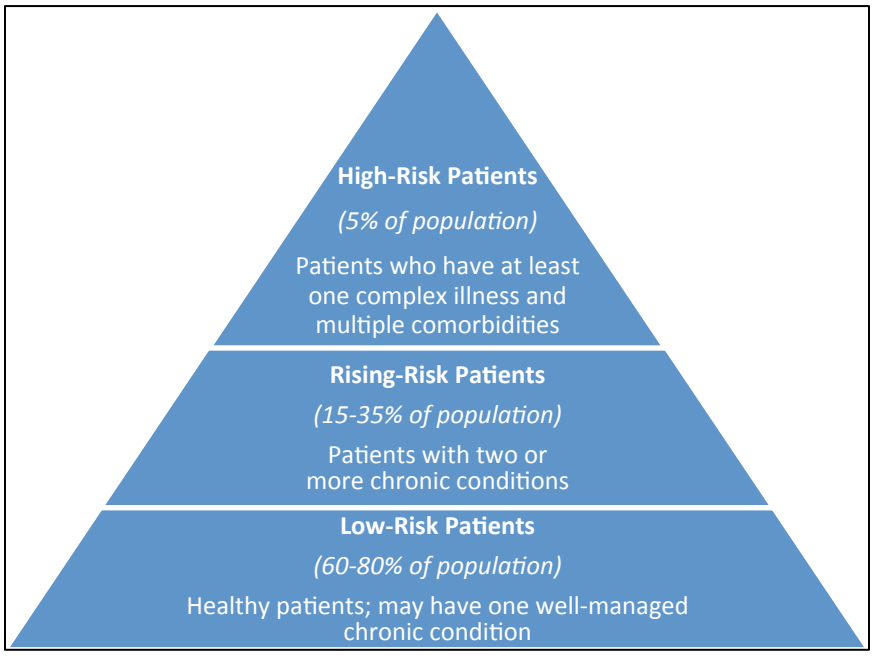
A. INTRODUCTION

The Rhode Island State Health Care Innovation Plan is a guide map with the objective to fundamentally change Rhode Island's health care system from one based on episodic care of illness and injury and supported by a volume-driven business model, to a system based on population health and supported by a business model rooted in value. This plan is designed to set the guideposts, to identify those steps that Rhode Island could take to maximize the opportunity for change in today's health care system. Each of the steps identified in the plan will require intense and detailed implementation planning. As such, this plan provides strategies for transforming the state's health care system, the context for those strategies and suggested tactics to bring the strategies to fruition. This plan should not be seen as the implementation blueprint, but rather a holistic model with the need for further debate and discussion on program details.

This plan was developed and created through a project funded by the Centers for Medicare and Medicaid Services, under the State Innovation Model program. Known as Healthy Rhode Island, the project focused on the development of the State Health Care Innovation Plan through extensive stakeholder engagement. With over 150 regular participants through a sixteen-week course of public convenings, and a three-week public comment period for this document itself, nearly every aspect represented in this plan has been discussed at some level. The focused effort on public feedback and dialogues has resulted in a plan that accurately reflects the trajectory of Rhode Island's health care system and actionable, realistic proposals to accelerate changes that support the "triple aim" of better health, better care and lower costs.

Balancing the goal of transforming the system of care in a way that supports the health of the population and lowers costs can be a challenging prospect, especially when faced with conflicting time horizons for such an activity. To create an effective balance, Rhode Island considers its population to consist of three distinct segments, as seen in Figure 1.

Figure 1.



Each of the three segments of the population has a different need and different strategies to reach the triple aim goals. Prevention and health promotion activities supported by community policies that support wellness, present the best opportunity to save money in the health care system and improve the health of the community. (Chang, Bultman, Drayton, Knight, Rattay, & Barrett, 2007) A singular focus on prevention and health promotion is an ideal strategy to improve the system for the low-risk patients, but has little effect on the high-risk and rising-risk groups and has a much longer time horizon for lowering costs. Likewise, intensive care management services are an ideal way to address the needs of the high-risk group and have proven to significantly reduce costs for this population. Investment in these types of care management programs, however, is targeted at a small group of individuals with little impact on the whole population's health.

This plan represents a blend of strategies to effectively address all populations, and in doing so, impact a preponderance of care across the state. There is no correct titration of investment across all of the population segments. Rhode Island's model will continually examine how well investments meet their intended goals and adjust as needed.

The plan will go into great detail on the need for change, the current environment, and opportunities to improve the health of Rhode Islanders. The plan is extensive, and for the sake of clarity and simplicity, there are some general terms that are used.

- **Provider / Provider Organization** – The plan references providers and provider organization frequently. Throughout the plan, the term providers and provider organizations are meant as broadly as possible. "Providers" includes, but is not limited to, physicians of all practices types and specialties, nurses of all practice levels, hospitals, long term care facilities, long term care service providers in the home and community, dentists and other oral health professionals, the clinical staff of physician practices and health care facilities, behavioral health facilities and professionals, and substance abuse treatment and recovery professionals. The term "provider organization" refers to formalized collaborations of these providers.

- **Lifelong System of Care** – The plan discusses a vision of a system of care, described as lifelong, that focuses on the person. This system of care is inclusive of pre-natal care, end of life care, and all lifestages in between. The system of care explicitly includes maternity care, pediatrics, school-based student health, adult primary care, family care, specialty care, behavioral health care, substance abuse treatment and recovery programs, oral health care, acute and emergent care, post-acute care, facility-based and home and community based long term care and hospice care.

Additionally, this plan is intended to encompass all payers in the Rhode Island health care system. While different payers, especially CMS-supported populations have distinct care needs, the envisioned system of care will be for all Rhode Islanders.

B. VISION STATEMENT

Healthy Rhode Island aims to achieve measurable improvement in health and productivity of all Rhode Islanders, and achieve better care while decreasing the overall cost of care.
We plan to transition from a disparate and health care provider and payer-centric environment to an organized delivery and payment system that is outcomes-oriented and person-centric.
-Purpose Statement of Healthy RI, the SIM Model Design Process

The World Health Organization's definition of health states, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." It would follow that a major sector in the state of Rhode Island referred to as "the health care system" would be primarily organized to ensure health for Rhode Islanders. However, few, if any, would agree that what is referred to as the "health care system" would meet that mission. The current system lacks coordination among health care providers, rewards providers with little to no regard to the quality of the care provided and struggles to meet the needs of all patients in terms of access to care.

Given the current environment of change in health care, the window of opportunity to change the health care system is open wider than it has been in a generation. The implementation of federal reforms, coupled with market changes, the aging of the population and breakdown of the old business model create an impetus for change, supported by an influx of persons into insurance coverage. It is in this period primed for change and innovation that Rhode Island seeks to take advantage of the opportunity and shape its health care system for the future. That health care system would have four main objectives: lifelong support of health and wellness, a focus on population health, coordinated models of care and payment transformation.

Rhode Island seeks to ensure a sustainable system of supports and services to attain and promote health, as defined above, for all of its residents. In doing so, Rhode Island recognizes that those residents will partner with payers and providers in the current health care system, as well as health related community-based organizations, to attain the vision of a new system of care.

The new sustainable system will support the health of Rhode Islanders, improve their experience and maintain a lower cost burden for them, government, employers and payers across the state. This will achieve the goals of the "Triple Aim," originally articulated by Donald Berwick, former Administrator of the Centers for Medicare and Medicaid Services (CMS). The "Triple Aim" is the achievement of better health and better care at lower cost. (Institute for Healthcare Improvement, 2013) Achieving these goals demands a transition to a value-based care paradigm for providers reaching at least 80% of the Rhode Island population within five years.

Lifelong support of health and wellness is conceptualized as pre-natal to grave. That is, the system of care is structured to provide Rhode Islanders with effective and appropriate care and support at all life stages – from effective, accessible and supportive pre-natal care to patient and family-centered support in the last moments of life. This objective requires a significant change in the orientation and focus of the health care system, supported by changes in the way in which providers are paid. The long term view of this change is that health promotion is fundamental to changing the trajectory of the health of the population and reducing the burden that disease and the medical care system has on our economy. (McGinnis, Williams-Russo, & Knickman, 2002)

The health care system has developed into a series of individual interactions between patient and health care provider. Not only has this evolution created an environment that struggles to coordinate the care of an individual when multiple providers are engaged in that individual's care, it also severs the relationship between the health care system and the community or population that is serves. Creating a focus on the overall health indicators of a population is a significant change for health providers. In fact, this year, Rhode Island hospitals undertook an effort to understand the health of Rhode Islanders and attempt to align their activities in the coming years with those health needs.

Accordingly, the state and its partners will focus on improving population health through organized care delivery systems that focus on patient activation and care coordination across the health care continuum with attention to high quality at a lower cost. Inherent in this effort is strengthening the link between care delivery systems, the community, its policies and priorities, and the organizations that fulfill those priorities.

In order to achieve this holistic framework, the state believes it is necessary to encourage and support the organization of payers, physicians, hospitals and other health care providers into coordinated care teams using payment models supported by Centers for Medicare and Medicaid Services. These payment models may include pay-for-performance, bundled payments, shared savings [inclusive of Accountable Care Organizations (ACOs) and ACO-like structures] and other forms of shared financial responsibility. The payment structure supports the transition from fee-for-service to a value-based model of reimbursement intended to encourage a collaborative approach to provide efficient, high quality and coordinated care to an attributed population of patients. As providers improve the health of their attributed population based on specified quality metrics and cost reductions, they may be eligible to receive financial rewards or share in the savings with contracted payers.

The successful transition and implementation of these payment models will be contingent on the provision of necessary tools to the provider at the point of service including, but not limited to, technology, data and analytics, and collaborative team members. The magnitude of change that will occur through a coordinated care model will require providers and payers to work together in new ways, deploying new tools and processes. Providers will need assistance to succeed the transition to this new collaborative environment.

The new system must be built to support a sustainable economic model for consumers (including patients, employers, insurers and taxpayers) and for providers. For that reason, efforts must be

undertaken to address those areas of the system where a lack of coordination leads to unnecessary cost growth and, often, a poorer quality of care. These changes include improving care transitions and engaging the patients that utilize the highest level of health resources. At the same time, investments in Rhode Island's future health must be made and preserved. Efforts to prevent disease or other conditions that detract from health should be considered part of the health system, despite their historical separation. These efforts include both traditional public health activities carried out by government as well as non-governmental organizations, and activities focused on building and maintaining health in communities.

The state sees the envisioned changes to the health system supported by six pillars – fundamental characteristics of the new value-based system. These pillars of the system are:

- Multi-payer – The new system of care must be adopted by a preponderance of payers in the state to ensure broad adoption of the new models.
- Payment Transformation – Systemic changes to how providers and provider organizations are paid are inherent in a move from fee-for-service to value-based payments methods.
- Patient/Consumer Centric – The new system must be realigned to support and engage patients and consumers as they maintain and improve health, and address injury and illness.
- Transparency – The system must provide insight into provider quality and cost and how their performance compares to their peers.
- Accountability – As the system moves away from fee-for-service, providers will become more accountable for the total cost of care, patient *and* population health outcomes. Additionally, the new system must be built upon the philosophy that patients, consumers, payers, and policy makers are all accountable for maintaining and improving the health of individuals across the state.
- Community Assets – Integrating the resources and assets that have a great impact on the health of Rhode Islanders, but were not historically considered part of the "health care system" will be a critical success factor in the new system.

Rhode Island's State Health Care Innovation Plan will identify where the current health care system supports or conflicts with these pillars and how proposed innovations build or bolster the pillars.

C. RHODE ISLAND AND ITS CURRENT HEALTH CARE SYSTEM

Rhode Island Demographics

Rhode Island, the nation's smallest state, has a population of approximately 1,050,292 (United States Census Bureau, 2013). The result of a population of such magnitude residing in a small geographic location is that the state is the second most densely populated with a density of approximately 1,005 people per square mile (WorldAtlas.Com, 2009). As of 2012, approximately 90.7% of Rhode Islanders could be considered to live in an urban area, compared to 80.7% nationally (State Health Access Data Assistance Center, 2012).

Approximately 76% of the state's residents are classified as white, non-Hispanic. The African-American population is 7.3% and the Hispanic population is 13.2% (United States Census Bureau, 2013). The Hispanic population has been growing at a very fast rate, increasing by almost 44% between the years 2000 and 2010 (Parker, 2013). Notably, there are health disparities between these groups.

Rhode Island has stood out in the past few years due to its unemployment rate; as of December, 2013, RI has the second highest unemployment rate in the nation and has been in the top five for at least four years. Rhode Island mirrors the national figures when it comes to poverty levels. For example, 22.9% of Rhode Islanders live below 138% of the poverty line, compared to 23.4% nationally (State Health Access Data Assistance Center, 2012).

The other demographic trend relevant to assessing population health is the percent of persons over the age of 65; standing at 14.4%, this proportion is higher than the national average of 13.1% (United States Census Bureau, 2013). Furthermore, according to the U.S Census figures in 2010, Rhode Island's percentage of seniors aged 85 or older is the highest in the nation at 17.61%. The Rhode Island Department of Administration's Division of Planning projected that 25% of the state's population will be 65 or older by 2040, and a significant portion of that will be over 85 (United States Census Bureau, 2013).

According to America's Health Rankings, there are disparities among different populations within the state. For example, a sedentary lifestyle is more prevalent among non-Hispanic blacks at 35.2 percent, than non-Hispanic whites at 23.3 percent. Obesity is more prevalent among non-Hispanic blacks at 35.7 percent than non-Hispanic whites at 24.7 percent and smoking is also more prevalent among non-Hispanic blacks at 15.4% than all Hispanics at 11.6% (United Health Foundation, 2013). According the Centers for Disease Control and Prevention, the national smoking rate for Hispanics is 12.9% (Centers for Disease Control and Prevention, 2013)

The Health of Rhode Island's Population and the Burden of Disease

Chronic Disease

Heart disease, stroke, diabetes, and arthritis are among the most common, costly, and preventable of all illnesses both in Rhode Island and nationally.[1,2,3] The tolls that these chronic disease take on our state are staggering.

- An estimated 7.4% (62,000) of Rhode Island adults have been diagnosed with diabetes. People with diabetes have medical expenditures 2.4 times higher than they would if they did not have diabetes. In Rhode Island, direct health care costs for adults with diabetes amount to an estimated $722 million annually.

- As of 2010, the annual mortality rate due to stroke in Rhode Island was 34 deaths per 100,000 population. Approximately a third of Rhode Island adults have been diagnosed with high blood pressure, a major cause of stroke.

- In Rhode Island, 29% adults have arthritis. Of these adults, 41% have activity limitation due to their arthritis.

As disconcerting as these figures are, these chronic diseases are largely preventable. Four modifiable risk factors—smoking, high blood pressure, overweight/obesity, and the lack of physical activity—are responsible for much of the illness and premature death related to these chronic diseases.[4] The higher prevalence of these risk factors among Rhode Island's Hispanic and non-Hispanic black populations and those of lower socioeconomic status explains a significant proportion of disparities in life expectancy in Rhode Island. This same pattern is consistently observed in other states.[5]

These four modifiable risk factors also serve as indicators of possible unmet community health needs. Access to high-quality and affordable preventative health care may greatly reduce a person's risk for developing chronic disease. Equally important is living in a neighborhood that is safe to walk in for individual and group exercise and where there is access to a high quality and affordable selection of fruits and vegetables and low fat foods.[6]

Table 1. Potentially Preventable Chronic Diseases and Associated Risk Factors in Rhode Island

Prevalence of Diagnosed Chronic Diseases Among Adults[1]

Heart Attack (ever told)	4.4%
Angina or Coronary Heart Disease (ever told)	4.2%
Stroke (ever told)	2.4%
Diabetes (ever told) (Excludes pregnancy-related diabetes)	8.4%
Asthma – Lifetime (ever told)	16.3%
Asthma – Current (ever told)	11.9%
Arthritis (ever told)[2]	26.7%
Prevalence of Four Major Modifiable Risk Factors – Adults[1]	
Overweight/obese[3]	62.5%
Hypertension (ever told)	32.9%
Current smoking	20.0%
No physical activity/exercise past 30 days[4]	26.2%
Hospital Discharges[5]	
Age-adjusted hospitalization rate per **10,000** Rhode Islanders ages 18+	
§ Cardiovascular disease	1179.0
• Heart Disease	814.2
§ Stroke	185.0
§ Diabetes	90.1
§ Osteoarthritis	147.0
Mor	

Age-adjusted mortality rate per 10,000 Rhode Islanders ages 18+

Cardiovascular disease	202.2
Heart Disease	165.6
Stroke	27.4
Diabetes	13.5
Arthritis	*

[1] 2011 Rhode Island Behavioral Risk Factor Surveillance System weighted data.

[2] Persons told by a doctor that they have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia.

[3] In 2011, 37.1% of adults were overweight and 25.4% were obese.

[4] Adults that reported doing no physical activity or exercise during the past 30 days, excluding their regular job.

[5] 2005-2009 Rhode Island Hospital Discharge Data 5-year aggregated file for the principal (1st) diagnosis.

[6] 2005-2009 Rhode Island Vital Record Death Certificate Data 5-year aggregated file for the underlying cause of death. * Too few deaths to report an age-adjusted rate.

Clustering of Risk Factors

Although each of the four major modifiable risk factors cited above (smoking, high blood pressure, overweight/obesity, physical inactivity) alone could devastate the health of an individual, they often do not affect people in isolated manners. They tend to cluster and act synergistically to increase the risk of developing one or more chronic conditions.[7,8,9,10] The clustering of these health behaviors or risk factors determines not only the occurrence and severity of a chronic disease, but also has important implications for health promotion.[11]

- Overweight and obesity increase risks of heart disease, stroke, type 2-diabetes, and osteoarthritis.
- Smoking, physical inactivity and high blood pressure (hypertension) increase the risks of heart disease, stroke, type 2 diabetes, and rheumatoid arthritis.
- Diets high in saturated fats increase the risks of heart disease and stroke, while high blood glucose (sugar) and high cholesterol increase the risk of type 2 diabetes.

Recent Rhode Island Behavioral Risk Factor Surveillance System data found that more than one-third of adults 20 to 64 years of age had at least one modifiable risk factor associated with cardiovascular disease and diabetes (36.2%), and an additional 44% of adults in this age group had two or more modifiable factors. This means that 252,614 Rhode Islanders between the ages of 20 and 64 years are at high risk for diabetes and heart disease.[12] Clustering of two or more risk factors was more prevalent among Rhode Islanders in the 20 to 64 year age group with a high school diploma or less education or who had household incomes that were lower than $25,000 per year. For example, low-income adults aged 20 to 64 years were more likely to report two or more modifiable risk factors than adults in this age group with household incomes of $50,000 a year and higher (55.0% versus 35.9%).[13]

Personal income and level of education, however, only partly explain disparities. The communities in which they live also affect individuals. Living in a high poverty neighborhood, as compared to a more economically affluent neighborhood, for example, has been shown to increase the risk of coronary heart disease in white residents by 70 to 90 percent and by 30 to 50 percent for African American residents. [14] Adults 55 years of age and older living in economically disadvantaged areas in the United States are at increased risk for developing heart problems and high blood pressure. Additionally, women in this age category in these communities are at increased risk for diabetes. Living in an area with higher levels of crime and more segregation increases the chances of developing cancer for women and men.

These findings may be the result of greater exposure to environmental toxins, such as hazardous waste and low quality water. The effect of stress on the body's ability to fight disease, which may be greater for those living in poverty, could be another contributing factor.

Tackling these preventable chronic diseases requires a closer look at two major risk factors— namely obesity and smoking. According to United Health Foundation America's Health Rankings, Rhode Island ranked 19th in the list of healthiest states in 2013, down from 16th in 2012.[i] Rhode Island can be proud of its ready availability of primary care physicians, and significant drop in adult and youth smoking rates over the past decade, in addition to high immunization coverage rates and low prevalence of obesity. However, large disparity in health status by education attainment, high rate of drug overdose deaths and high rate of preventable hospitalizations are the biggest challenges and are offsetting improvements in Rhode Island's national health ranking.

The percentage of Rhode Island adults that smoke is not yet at the Healthy People 2020 level of 12% for adults aged 18+.[ii] Rhode Island's Behavioral Risk Factor Surveillance System (BRFSS) data show that self-reported adult cigarette smoking rates have stalled in recent years. Twenty percent of Rhode Island adults were current smokers in 2011 (95% confidence intervals [CI]:18.6-21.5), dropping to 17% in 2012 (95% CI: 16.0-18.9); not a statistically significant decrease.

Rhode Island has made impressive strides in the reduction of smoking rates among high school aged youth (8.0% in 2013; down from 19.3% in 2003); a significant decrease over ten years. Yet the growing popularity of other tobacco products among teens is of concern. The percentage of high school students that currently smoke cigars, cigarillos, or little cigars has remained unchanged over the past ten years (2003: 10.5%; 2013: 9.4%) and the use of smokeless tobacco products (chewing tobacco, snuff or dip) has significantly increased (4.6% in 2003 to 7.0% in 2013). People who start smoking or using smokeless tobacco products in adolescence have a harder time quitting as adults.

Overweight and obesity are major public health crises nationally and in Rhode Island. The prevalence of overweight and obese adults in Rhode Island has increased dramatically in recent decades. In 2012, 37.2 percent of Rhode Island adults were overweight (95% CI: 35.3-39.0) and 25.7% were obese (95% CI: 24.1 –27.4). As troubling, Rhode Island's Youth Risky Behavior Survey data show that the percentage of adolescents who are overweight or obese has not changed in the past decade. An estimated 14.4% of high school youth were overweight in 2003, as were 16.2% in 2013. In 2003, 9.8% of adolescents were obese, reaching 10.7% in 2013. It is well known that obese children and adolescents have increased odds of a wide range of physical and psychosocial problems,[iii] and are more likely to be obese as adults with lifelong physical and mental health problems.

Of particular importance from a public health perspective, are disparities in the prevalence of chronic diseases and associated risk factors. Rhode Island's BRFSS data show that socioeconomic disparities, whether measured by education or household income, persist for self-reported chronic disease risk factors (current smoking, overweight/obesity) as well as for diabetes. In 2012, for example, Rhode Island adults who were high school graduates or had fewer years of education were significantly more likely than those with a college education to report that they currently smoked (23.0% vs. 13.2%), to have a body mass index (BMI) classified as obese (28.6% vs. 23.6%), and to have diagnosed diabetes (11.8% vs. 8.6%). The prevalence of prediabetes did not vary by education or household income. In 2012, 6.5% of Rhode Island adults reported being diagnosed with prediabetes (95% CI: 5.5-7.4), excluding women with prediabetes during pregnancy.

Studies have shown that chronic disease risk factors act synergistically to increase the risk of developing one or more chronic conditions.[iv,v,vi] Analysis of the 2012 Rhode Island BRFSS found that 36% of adults 20 to 64 years of age had at least one modifiable chronic disease risk factor associated with diabetes (smoking or obesity). 6% of Rhode Islanders ages 20–64 reported having both modifiable risk factors. This represents 33,552 Rhode Island adults at high risk for diabetes. Obesity has been historically known as a risk factor for type 2 diabetes.[vii] Researchers have long known that people with type 2 diabetes who smoke have higher blood sugar levels, making their disease more difficult to control and putting them at greater danger of developing complications such as kidney failure and heart disease.[viii] Clustering of these two modifiable chronic disease risk factors was common and significantly higher in adults with lower socioeconomic status.

Health disparities by income or education only partly explain disparities in health outcomes. Social determinants of health are shaped by the distribution of money and resources throughout communities. The impact of the recent U.S. economic recession, the longest, and by most measures the most severe since World War II, on the health of children and adults, and across racial/ethnic and socioeconomic groups is a new area of research.

During the recession of 2008 and 2009, Rhode Island's unemployment rates reached a record high of 12.7%; dropping only to 9.8% in January 2013, the highest in the country along with California (9.8%).[ix] Unemployment among Hispanics and blacks in Rhode Island has shown little improvement from the high levels that prevailed throughout the recession years of 2008-2010. In the fourth quarter of 2012, the Hispanic unemployment rate was 18.2% in Rhode Island, the highest nationally for Hispanic adults, compared with 10.3% for all Rhode Island workers.[x] The average unemployment rate for Rhode Island's black population increased to 17.6 percent in 2011, up from 15.7 percent in 2010, due to increased unemployment among black men.[xi] The average unemployment rate for Rhode Island's adult white population fell from 10.8 in 2010 to 9.0 percent at the end of 2012.[17] Rhode Island's unusually high unemployment rate is not expected to significantly change in the next two to five years. Widespread unemployment in neighborhoods reduces resources, often resulting in high home foreclosures, underfunded schools, and restricted access to services and public transportation, making it more difficult for people to return to work. When a state like RI experiences high unemployment rates the fabric of a community is deeply impacted and the health of its residents is adversely affected.

The Rhode Island Department of Health has been in the forefront of collecting population-based data on neighborhood risk and resilience factors in relation to health outcomes. In 2005, 2007, 2009, and 2011 the Rhode Island Behavioral Risk Factor Surveillance System included a nine question Social Capital module, which assessed connections among individual social networks and the norms of reciprocity and trustworthiness that arise from them. Respondents were asked about their participation in and willingness to volunteer for community events, belief that people can make a difference in their community, and perceptions of community-level trust and reciprocity. Adults with household incomes less than $25,000 per year and those with less than a high school education were more likely to have negative responses to indicators of social capital than adults with higher incomes or more formal years of education. Adults who perceived their communities as having more social liabilities than assets were more likely to report being diagnosed with diabetes or being a smoker.

Potentially preventable hospitalizations. One area where higher quality and lower costs coincide is potentially preventable hospital admissions. These are inpatient stays that could be prevented with high-quality primary and preventive care, although not all such hospitalizations can be avoided. Potentially preventable hospitalizations for adults include diabetes, circulatory diseases, chronic respiratory diseases, and select acute conditions.[xii]

Rhode Island's four-year aggregated Hospital Discharge Data (2009 – 2012) reveal striking disparities. Among adults aged 18 and older, the average annual (crude) hospitalization rate when diabetes was the principal (primary) reason for an inpatient admission was 483 per 100,000 for non-Hispanic blacks, 187 per 100,000 for Hispanics, and 171 per 100,000 for non-Hispanic whites. The rate for non-Hispanic blacks was nearly 3.0 times higher than non-Hispanic whites, and 2.5 times higher for non-Hispanic blacks than Hispanics. Diabetes inpatient admissions are costly. In 2012, the overall hospital costs of an inpatient stay when diabetes was the principal reason for admission for patients aged 18 and older (n= 1589) were nearly $14 million ($13,621,042), with an average cost of $8,573.

Behavioral Health and Substance Abuse

Behavioral health is the largest single source of burden of disease in the state of Rhode Island. No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact (Murray & Lopez, A., 1996; Surgeon General Report, 2000; Kessler, et al,. 1994, 1996). Behavioral health is an integral part of health – there is no health without mental health (Surgeon General Report, 2000). There is a strong moral and a substantial economic case for Rhode Island to adequately address the challenge of mental health and addiction problems for people who experience them in their communities (President's New Freedom Commission on Mental Health, 2003).

General Mental Health - During 2012, nearly one in six (16.4%) of Rhode Island adults indicated that their mental health was not good for more than seven days in the past 30 days. Rates were highest among the following groups: those with household incomes less than $25K; those with less than a high school education; younger adults; non-white, non-Hispanics; and women. For example, nearly one-third (32.8%) of adults with annual household incomes of less than $15K per year reported poor mental health compared to only 9% of adults with incomes of $75K or higher. Adults with less than a high school education were twice as likely to report poor mental health compared to those with a college education. One in five young adults aged less than 25 (20.5%) reported poor mental health compared to 10.0% of those aged 65 or older. Those of races other than white and black, non-Hispanics reported higher rates of poor mental health (19.9%) compared to white, non-Hispanics (16.6%) and those of Hispanic ethnicity (13.9%). Women reported higher rates of poor mental health (18.3%) compared to men (14.4%).

Depressive Disorders - One in five (20.3%) Rhode Island adults reported having a depressive disorder. This figure was highest among those with annual household incomes of less than $15,000 (38.7%), which

was 3.6 times higher than those with incomes of $75,000 or more. Nearly one-third (31.5%) of adults with less than a high school education reported having a depressive disorder, more than twice the rate for those with a college education (14.1%). Women were more likely to report having a depressive disorder (24.6%) compared to men (15.7%).

Alcohol Use - The prevalence of heavy drinking (adult men having more than two drinks per day and adult women having more than one drink per day) is 6.2%. The percent of RI adults who binge drink (males having five or more drinks on one occasion, females having four or more drinks on one occasion) is 17.2%. Males are more likely to binge drink (22.6%) than women (12.3%). The likelihood of binge drinking deceases with age. For example, adults aged 18-24 had the highest rate of binge drinking (29.4%) and adults aged 65 and older had the lowest rate (4.0%).

Serious Mental Health Illness - According to a report recently published by the Mental Health Association of Rhode Island (*Mental Health Measures Rhode Island New England State and United States, December 2013),* 7% of Rhode Island adults aged 18 or older have serious mental illness (SMI) compared with 4-5% for other New England states and the United States (5%). These data are from the National Survey on Drug Use and Health, which surveys a representative sample of the national population and is based on 2008-2009 data. Almost one in four (24%) Rhode Island adults have any mental illness (AMI) compared with one in five (20%) for other New England states and the US. The source for these data is *Mental Health United States, 2010, Table 98*.

Oral Health

Oral health status has improved for many Rhode Islanders over the past decade, but oral diseases still cause pain and disability for adults and children each year. More importantly, the burden of oral diseases is distributed unevenly among different populations. Disparities in oral health status exist among minority racial/ethnic groups, people of low socioeconomic status, and those who are underinsured or uninsured. Beyond these demographic risk factors, special healthcare needs, diabetes, pregnancy, and age constitute additional risk factors for common oral diseases or for oral disease-related health complications.

ORAL DISEASES

Dental Caries (Tooth Decay) - Dental caries is the most common chronic disease of childhood, both nationally and in Rhode Island. Unchecked, dental caries can result in loss of tooth structure, inadequate tooth function, unsightly appearance, pain, infection, and tooth loss. The pain and disability caused by untreated dental caries may limit children's ability to focus and perform in the classroom, causing them to miss school days and fall behind their peers. Significant disparities exist in the incidence of dental caries and untreated decay among Rhode Island children from different racial/ethnic and socioeconomic backgrounds. For example, Rhode Island third graders who are Hispanic or who attend schools with high student enrollment in free and reduced school meal (FRSM) programs are more likely to experience dental caries than their peers (High FRSM: 58%; Hispanic: 54%; Black: 47%; White: 46%; Low FRSM: 42%). Adults also are at risk for dental caries and can experience decay on the exposed crown portion of

a tooth or on the root surfaces of teeth that are exposed as gums recede. About one in five Rhode Island adults age 35–44 years self-report tooth decay.

Tooth Loss - Tooth loss affects a person's ability to chew and speak and can interfere with social functioning. With adequate personal, professional, and population-based preventive practices, most adults keep their full set of teeth throughout their lives. Since 2000, statewide trends in tooth loss have improved among Rhode Island adults. The percentage of adults age 35–44 years who have never had a permanent tooth extracted due to dental caries or periodontal disease increased from 61% in 2000 to 69% in 2008. Compared to their counterparts, more adults of minority race, with less education, and/or with lower income report having one or more teeth lost due to dental caries and periodontal disease (Figure 1). The percentage of adults age 65–74 years with complete tooth loss (edentulism) decreased from 23% in 2000 to 13% in 2008. For Rhode Island adults age 65+ years, edentulism is more common among those with lower education and income levels.

Oral Cancer - Oral cancer includes cancer of the oral cavity or pharynx. Nationally, oral cancer is the sixth most common cancer in black men and the eighth most common cancer in white men. Oral and pharyngeal cancers also are a significant issue in Rhode Island, particularly among men.

RISK FACTORS

Pregnancy Status - Oral health is an integral component of overall health and well being for women and is particularly important prior to conception and during pregnancy. Recent evidence suggests that oral infections such as periodontitis during pregnancy may increase the risk of preterm or low birth weight deliveries. In fact, pregnant women who have periodontal disease may be seven times more likely to have a baby that is born too early and too small.

Diabetes - Diabetes is a recognized risk factor for severe and progressive periodontal disease, which can result in the destruction of tissues and supporting bone around teeth. Despite their increased risks, data suggests that Rhode Island adults with diabetes access dental care at lower rates than their non-diabetic peers.

Age - Older adults with poor general health may have difficulty maintaining adequate oral hygiene, visiting a dental office, or tolerating dental treatment due to limited dexterity, visual or mental acuteness, mobility, and stress tolerance. Oral cancers also occur primarily in adults age 65+ years and may sometimes go unrecognized and untreated in the absence of routine dental visits.

Costs of Care in Rhode Island

The following table estimates the monthly spending per person by health coverage type:

Payer	Population	Population Estimate	Spending Per Member Per Month (PMPM)
Medicaid/CHIP	Adult	43,545	**$416**
Medicaid/CHIP	Child	83,133	**$216**

Additionally, Rhode Island examined expenditures in different health service lines, as described in the table below:

Cost of Care by Service Category	Medicaid PMPM	Medicare PMPM	Commercial PMPM
Inpatient Hospital	$ 70.31	$ 348.76	$ 83.08
Outpatient Hospital (total)	111.09	148.96	92.13
Emergency Dept (subtotal)	*22.30*	*26.99*	*17.76*
Professional Primary Care	16.19	41.69	31.44
Professional Specialty Care	33.71	119.25	59.59
Diagnostic Imaging/X-Ray	3.27	22.30	11.99
Laboratory Services	3.06	15.15	5.87
DME	6.73	13.18	3.87
Dialysis Procedures	0.08	0.07	0.33
Professional Other (e.g., PT, OT)	28.01	0.04	10.09
Skilled Nursing Facility	0.90	109.33	1.65
Home Health	10.38	44.39	2.73
Nursing Home	138.29	-	-
ICF/MR	3.58	-	-
Home and Community-Based Servi	36.90	-	-
Other	82.82	58.07	1.98
Professional Specialty Care	33.71	119.25	59.59
Subtotal	**$ 579.04**	**$ 1,040.42**	**$ 364.34**
Prescription Drugs (Outpatient)	41.34	162.72	76.29
Total	**$ 620.38**	**$ 1,203.14**	**$ 440.63**

Current Health Care System Model

The health care and social assistance sector in Rhode Island is large and vibrant, making up 20% percent of the Rhode Island employment market. (Rhode Island Department of Labor and Training, 2012).

Below are the central health care organizations in the State and descriptions of some of the key relationships among them.

Physicians and Other Health Care Providers:

PRIMARY CARE

According to a report completed by the Robert Graham Center in March of 2013 on behalf of the state's Health Care Planning and Accountability Advisory Council, there are approximately 841 primary care physicians in the state, a figure that includes family medicine, geriatricians, general practitioners, internal medicine practitioners and pediatricians (Robert Graham Center, 2013). According to the same study, these physicians account for approximately 32.8% of all medical providers, which is similar to the national figure of 33.3%

The Graham Center report also indicates that there are approximately 1,726 specialists in Rhode Island, accounting for 67.2% of the physician supply, which is similar to the national figure of 66.7%. Further, the Graham Center found that there are a total of 422 Nurse Practitioners and 277 Physician Assistants in the state. When the Graham Center looked at physician to population ratios, the Center found that Rhode Island ranks 8th in the nation for primary care and 6th in the nation for specialty care.

There are two large aggregations of primary care physicians in the Rhode Island marketplace:

> *Coastal Medical Practice* – an ACO comprised entirely of physicians and supporting staff (101+ physicians, nurse practitioners and physician assistants). The organization began as a primary care practice but has expanded to include some specialties such as cardiology, pulmonary, pediatrics and infectious diseases. They have a patient panel of approximately 105,000, including some Massachusetts residents, and some of their physicians are members of CSI-RI. In 2007, they made a strategic decision to start engaging in pay-for-performance contracts. In 2009, they put PCMH at the center of their strategy, focused on meaningful use and became involved with the state Beacon project (see below for more on Beacon). In 2011, they began to pursue shared savings arrangements with BCBSRI as well as United and Tufts. Currently, they are in the Medicare Shared Savings Program.
>
> *Rhode Island Primary Care Physicians Corporation (RIPCP)* – An independent physicians association, the group represents over 150 physicians in the State. It contracts directly with both major insurance providers and supports its members' efforts to become recognized as National Committee on Quality Assurance (NCQA) PCMH's. RIPCP has more than 45 practices that have achieved recognition as Level 1 NCQA PCMH.

A significant number of primary care physicians in the state belong to very small practices, or practice independently. According to the Graham Report, the median primary care practice size in Rhode Island is slightly smaller than other states (11 physicians compared to 12 nationally and 14 in other New England States). Approximately 27% of primary care physicians are in practices with three or fewer

physicians (Robert Graham Center, 2013). These independent physicians represent a significant focus of the innovation efforts in the State.

Physician Organizations:

With a few exceptions, Rhode Island lacks the large multi-practice physician organizations that exist in other parts of the country. The largest physician organizations in the state are the, Lifespan/Physician Services Organization with 800 physicians, the Women & Infants Physician-Hospital Organization (PHO) with 220 physicians, and the Providence and Kent PHO with 200 physicians. Coastal Medical is the largest primary care physician organization in the state with approximately 85 physicians. The Rhode Island Primary Care Physicians is an independent physician association with approximately 163 independent primary care physicians. The rest of the physician groups are smaller or comprised of a single specialty, such as Rhode Island Medical Imaging, which is a group of fifty-three radiologists. Although there are large Physician Hospital Organizations, these entities have not engaged in any meaningful value-based contracting to date.

Hospital and Health Systems:

The environment is rapidly changing for the hospitals and health care systems in Rhode Island. There have been several recent mergers and purchases representing consolidation within the state, and another two pending purchases proposed by separate out-of-state for-profit systems for three hospitals; these pending purchases as of October, 2013 are in different stages of the review/approval process in the Department of Health and the Attorney General's office.

Rhode Island has witnessed the development of hospital systems over the past few decades.

> *Care New England*: a non-profit organization comprised of Butler Hospital, Kent Hospital, and Women and Infants Hospital with an agreement to purchase Pawtucket Memorial Hospital.
>
> *Lifespan:* a not-for-profit health care system based in Providence, RI. Formed in 1994, Lifespan includes three teaching hospitals of The Warren Alpert Medical School of Brown University: Rhode Island Hospital and its Hasbro Children's Hospital; The Miriam Hospital; and Bradley Hospital, the nation's first psychiatric hospital for children. Lifespan also includes Newport Hospital, a community-based hospital in Newport, RI. and Gateway Healthcare Inc a statewide community health and family services agency. Lifespan hospitals are among the top recipients in the country of research funding from the National Institutes of Health.
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> .

Care New England and Lifespan account for 80% of Rhode Island's hospital beds (American Hospital Association, 2013). By focusing efforts with these two systems, it is expected that the state's health care innovation plan can make great strides with few touch points.

> *CharterCare*: a non-profit organization comprised of Roger Williams Medical Center, Our Lady of Fatima Hospital and St. Joseph Health Services. Recently it was announced that Prospect

Medical Holdings a for-profit hospital chain based in CA, has signed an asset purchase agreement with Chartercare. Regulatory review of the purchase had not begun as of this plan.

Other hospitals: Westerly Hospital, South County Hospital, Landmark Hospital, the Providence VA Medical Center and the Eleanor Slater Public Hospital (495 beds on two campuses).

In 2008, Landmark Hospital in Woonsocket entered receivership. At the time of this publishing, the hospital had cleared all regulatory hurdles to proceed with a purchase by Prime Medical Services, an 18 hospital for-profit chain based in California. This would make Landmark the first for-profit hospital in the state. In 2013, Westerly Hospital (in receivership since 2011) was purchased by Lawrence and Memorial of New London Connecticut, and Care New England announced its intention to purchase Memorial Hospital. In addition, Prospect Medical Holdings of California recently signed an intention to purchase the CharterCARE Hospital System. A 2012 study commissioned by Health Care Planning and Accountability Council (HCPAAC) showed that there is projected to be a surplus of hospital beds of between 100 and 200 beds, in the next several years (The Lewin Group, 2013). While the report did not specify geographics of the bed supply, the finding continues to inform public opinion that health care in Rhode Island needs a more focused planning effort.

TABLE 1: RHODE ISLAND HOSPITALS

Hospital	Health System	City	Licensed Beds as of December 2013	Notes
Butler Hospital	Care New England	Providence	143	Psychiatric
Kent Hospital	Care New England	Warwick	359	
Women & Infants Hospital of RI	Care New England	Providence	167	Maternity, NICU
Memorial Hospital of Rhode Island	Under agreement to be purchased by Care New England	Pawtucket	294	
Roger Williams Medical Center	CharterCARE	Providence	220	
Our Lady of Fatima Hospital	CharterCARE	North Providence	359	
The Westerly Hospital	Lawrence +Memorial of New London, CT	Westerly	125	
Rhode Island Hospital, Hasbro Children's Hospital	Lifespan	Providence	719	Level I Trauma
Newport Hospital	Lifespan	Newport	129	
The Miriam Hospital	Lifespan	Providence	247	
Emma Pendleton Bradley Hospital	Lifespan	Providence	60	Children's Psychiatric
Eleanor Slater Hospital	State-owned	Pascoag/Cranston campuses	495	Long term care only
Landmark Medical Center	Under agreement to be purchased by Prime Healthcare	Woonsocket	214	Approved by state regulators, Sale Pending
Providence VA Medical Center	Veteran's Administration	Providence	73*	
South County Hospital	Independent	Wakefield	100	
Rehabilitation Hospital	Under agreement to be purchased by Prime Healthcare	Woonsocket	82	

Source: The Lewin Group, 2013

Federally Qualified Health Centers:

Rhode Island has eight Federally Qualified Health Centers (FHQC's) that serve approximately 123,035 patients: 31% of these patients are currently uninsured and Medicaid covers 42.6%. East Bay Family Health, Thundermist Health Center of West Warwick, and WellOne Primary Medical and Dental Care are participating in CMS' FQHC Advanced Primary Care Practice Demonstration. This is a three-year program that will show how the PCMH model can improve quality of care, to promote the Triple Aim. Three FQHCs are also participating in the CSI-RI, the state's patient-centered medical home program.

TABLE 2: FQHC'S IN RHODE ISLAND

FQHC	City	Patients Served in 2012
Blackstone Valley Community Health Care	Pawtucket	11,888
Comprehensive Community Action, Inc	Cranston	13,341
East Bay Community Action Program	Newport	8,542
Northwest Community Healthcare (WellOne)	Pascoag	13,330
The Providence Community Health Centers, Inc	Providence	39,839
Thundermist Health Center	Woonsocket, W. Warwick and Wakefield	35,604
Tri-town Economic Opportunity Committee	Johnston	5,285
Wood River Health Services, Inc	Hope Valley	7,076

Behavioral Health System

Similar to the medical care system, the behavioral health system in Rhode Island has developed into a fragmented system of payers and providers. The fragmentation, developed due to multiple funding streams for behavioral health services and the discordant policy goals of each of the funders, lends to different systems of care depending on coverage type and diagnosis.

HOSPITAL CARE

Rhode Island has a unique "State" hospital system in that long term inpatient care is provided at the state operated general hospital, while acute psychiatric care is provided by private hospitals. Decisions around acute psychiatric hospitalizations are generally made by the hospitals, particularly after hours with the assistance of Qualified Mental Health professionals with whom they have contracts. However, behavioral health crises among uninsured consumers are managed through a state program to provide an array of diversion, hospital alternative and psychiatric hospitalization.

The state has set a goal for reduction of hospitalization, promoting the policy that long term care hospitalization should be provided only for those seriously mentally ill adults for whom community services are not available. The number of state-funded hospital psychiatric service admissions in state fiscal year 2013 was 845.

COMMUNITY MENTAL HEALTH ORGANIZATIONS

Rhode Island's community mental health services are provided by its network of Community Mental Health Organizations (CMHO). The CMHOs, which grew out of Rhode Island's 1962 Community Mental Health Law and the federal Community Mental Health Organization Act, form a fully integrated statewide mental health delivery system based on a single comprehensive CMHO in each of the state's catchment areas These services are provided for those with chronic and persistent mental illness and are largely funded through the state's Department of Behavioral Health, Disabilities and Hospitals. Following the merger of several of the original eight catchment-based CMHOs, six regionally-based CMHOs are responsible for the provision of all outpatient public mental health services in the state's eight catchment areas. Each CMHO provides prevention, emergency, general outpatient, and community support services:

- **Wellness Promotion** includes a) consultation to other health, mental health, law enforcement and human service providers to assist them to recognize and address mental health problems among their clients, and b) community education regarding the nature of mental illness and development of a positive attitude toward its prevention and treatment.
- **Emergency Service** is an immediate response by mental health professionals 24 hours per day, 7 days per week, to anyone experiencing a psychiatric emergency. It can include psychiatric assessment, crisis intervention, medication, short-term counseling, referral, face-to-face assessment by a qualified mental health professional, case management and admission to an inpatient unit when necessary.
- **General Outpatient (GOP) Service** is provided for people suffering from a degree of mental illness or emotional distress adversely affecting their level of functioning but not severe or long-lasting enough to be disabling. General Outpatient treatment programs provide an array of services that include but are not limited to individual, group and family counseling, and education. These programs offer comprehensive and coordinated diagnostic, clinical, and educational services that may vary in intensity level according to the needs of the individual served.

Community Support Service (CSP, Community Support Program) is the provision of care to individuals residing in the community who meet criteria for being Seriously and Persistently Mentally Ill. Services to SPMI clients are delivered using a treatment team model similar to ACT. All CSP-eligible clients have access to an array of intensive, community-based care coordination, health promotion and case management.

TABLE 3: CMHO'S IN RHODE ISLAND

CMHO	City	Approximate # Clients Served Annually
East Bay Center, Inc	East Providence	3000+
Fellowship	Lincoln	RI #'s not broken

Health Resources, Inc		out in annual report
Gateway Healthcare, Inc	Pawtucket (recently purchased by Lifespan)	15,000+
The Kent Center for Human & Organizational Development	Warwick	4,000+
Newport County Community Mental Health Center, Inc	Middletown	1814*
NRI Community Services, Inc	Woonsocket	3900
The Providence Center	Providence	12,123
Riverwood Mental Health Services	Warren	500

*FY2013

In addition to the CMHO's and hospitals, the state has an array of behavior health professionals in private practice who serve those with mild to moderate mental illness. Anecdotal reports suggest a lack of services for children and elders, however, there is not a reliable data source to support that claim. The state's Health Care Planning and Accountability Advisory Council is currently undertaking an analysis of the supply of behavioral health services in the state. Improvements in our mental health service delivery system, better coordination of services and more effective integration of mental health and primary care are vital to high quality patient-centered care. This is an enormous challenge and opportunity for Rhode Island.

SUBTANCE ABUSE TREATMENT AND RECOVERY

The Department of Behavioral Health Care, Developmental Disabilities and Hospitals (BHDDH) is the designated single state authority (SSA) for substance abuse treatment and prevention services. The treatment team within the Division of Behavioral Health (DBH) is responsible for monitoring the delivery of an array of treatment services, across the ASAM continuum of care. Through the SAPT and through

use of Medicaid and state dollars, BHDDH funds community providers in all areas of the state who provide a comprehensive array of services for uninsured Rhode Islanders.

Substance abuse outpatient services are provided through five prime contractors serving five regions: Providence County--South (immediate metro City of Providence), Providence County--North, Kent County, Washington County, and Newport-Bristol Counties. Each prime contractor is responsible for insuring a comprehensive continuum of outpatient services including individual and group counseling, intensive outpatient, and partial hospitalization (e.g., day hospital).

The SSA funds a single, statewide medical detoxification/acute psychiatric hospitalization program. This program provides detoxification services, including a secure unit for individuals with suicide ideation in need of detoxification. The contract also supports the use of outpatient detox treatment, and step-down services for continued stabilization, but does not provide medication monitoring. The service has increased the number of individuals who are connected with outpatient or opioid treatment upon discharge from detox.

The Department has recently re-contracted for adult substance abuse residential treatment services. Residences are now gender-specific. There are now six men's and six women's treatment facilities across the state providing gender-specific treatment. The new contract provides for programs at each of the ASAM-PPC-2 levels, which allows for a better match of client needs to programs. Two new levels have been added: a two-bed "respite/crisis" contract for women and a "short-term transitional" level at nine of the programs. Also, the provision of recovery housing has been formalized. All state funds for recovery housing are now implemented and monitored by an agency licensed in Rhode Island which maintains MOUs with each recovery house and requires that the programs maintain Level III of the National Accredited Recovery House standards. Finally, the new contract encourages all providers to enhance their provision of a recovery oriented system of care by utilizing a full continuum of care and by adding and supporting recovery housing.

The state has continued to fund Medication Assisted Treatment. Six agencies with twelve sites provide statewide MAT. Three of the programs are funded by the Department for uninsured clients. Also, a number of physicians who are not funded by BHDDH provide Medicaid-covered suboxone treatment, and many of these provide clinical services for other service providers by contract.

INTERVENOUS DRUG USE

The SSA functions as the state Opioid Treatment Authority. The SSA currently funds eight of the twelve authorized opioid treatment programs in the state. Funded treatment slots are geographically dispersed throughout the state to increase treatment accessibility for patients. Opioid Treatment Programs are expected to incorporate best practices based on SAMHSA's TIP 43. For opioid dependent patients who have required a higher level of care, dual enrollment is available for both residential and more intensive outpatient services

The state also:

- Continues to implement capacity management and wait list systems strategies.
- Continues collaboration with the Department of Health's ENCORE program (Education, Needle Exchange, Counseling, Outreach and Referral) which is an HIV (and other Blood-borne pathogens) prevention/intervention aimed at injecting drug users (note: no Block Grant dollars were used for needle exchange activity)

All contracts with programs funded by the Block Grant include language requiring that they conduct outreach activities to intercede specifically with IVDUs, in order to provide HIV counseling, and refer individuals to treatment or medical/other support. Although not funded by BHDDH, the Department of Health (DOH) and their community programs provided a wide range of street outreach activities to intravenous drug users designed to reduce harm and refer IVDUs to treatment. In addition, BHDDH and DOH regularly collaborate. The Department is a standing member of the Department of Health-lead Drug Overdose Rescue Coalition, which also includes representatives of the medical and pharmacy treatment communities.

Oral Health Care

Rhode Island's oral health system, like most states, had developed in a separate system of care than the medical system. Approximately 97% of Rhode Island dentists work in private practices, while 3% work in a public health setting, such as in a dental safety net site. During the past decade, the state has significantly enhanced access for children to oral health services, especially at the health centers in our state and at Lifespan's Samuels Sinclair Dental Clinic. Rhode island also continues to cover dental services for adults in our Medicaid program and has created a successful mobile treatment capacity for seniors in nursing homes. To continue to improve oral health outcomes and eliminate disparities, Rhode Island's oral health workforce must provide both preventive and restorative care for individuals in all settings. The co-location of oral health and other health services at our health centers offers an opportunity to re-integrate oral health with other aspects of physical health. In addition, the state should continuously monitor dental workforce trends to assure a sufficient provider supply and develop responsive, flexible workforce strategies.

The dental team is comprised of dentists, dental hygienists, dental assistants, and laboratory technicians. This team can work in private practice, within a dental safety net site, such as a community health center, hospital or clinic, and/or volunteer their time and services.

As of September 2010, 619 actively licensed dentists were practicing in Rhode Island, or 59 dentists per 100,000 Rhode Island residents. Rhode Island's dentist to population ratio is favorable when compared to the national average (47:100,000). However, dentists are not evenly distributed across the state, and they do not uniformly accept individuals with all types of insurance coverage. Increased shortages are expected in the next decade: more than half of actively practicing Rhode Island dentists are approaching retirement age (50+ years) (Figure 9), and the state has a less than optimal supply of expert faculty to train students seeking entry into this profession. Most importantly, these shortages will likely impact the state's most underserved populations—families with low income, individuals with special health care needs, elders in nursing facilities, and people of minority race/ethnicity.

As of September 2010, 713 actively licensed registered dental hygienists were practicing in Rhode Island. Dental hygienists in Rhode Island practice under "general supervision," which means that a dentist must authorize the procedures to be performed but need not be present while the dental hygienist provides the services. Dental hygienists in other states have less restrictive supervision and can perform expanded functions, such as placement of restorative materials, periodontal dressing, suture removal, and metal restoration polishing. Revisiting regulatory requirements for dental hygienists to expand their roles may allow Rhode Island to improve access to oral health care services, particularly for vulnerable populations who are not able to access traditional dental practices, either due to geographical, cultural, or financial barriers.

Rhode Island does not license dental assistants, making it difficult to quantify the number currently practicing in Rhode Island. Without licensure, continuing education is not required; therefore, mastery of topics, such as infection control and radiation health and safety, whose content changes over time, is not a requirement for employment. Education in these topics may increase the safety of both dental assistants and their patients.

Long Term Care

There are 84 long term care facilities in Rhode Island. Most of them are independently owned and approximately 80.5% are for-profit. The remaining facilities are non-profit, including the state-run Veterans Home (Centers for Medicare and Medicaid Services, 2011). According to CMS, Rhode Island has one of the highest rates in the country of nursing home beds per thousand persons aged 65 or older (Centers for Medicare and Medicaid Services, 2011).

Carelink is an entity in the long term-care community. It is a non-profit management service organization that supports the business activities of three Adult Day Care services, four Home Health Care agencies, three independent living facilities, six Assisted Living Facilities, seven Nursing Homes and one hospice agency. Carelink serves as one of the two organizations chosen to manage the Integrated Care Initiative (described more fully below) for individuals dually eligible for Medicare and Medicaid. Carelink manages the PACE-RI program:

> *Program of All-Inclusive Care for the Elderly (PACE) Organization of Rhode Island:* Established in 2005, in Rhode Island, by Carelink, the PACE Organization of Rhode Island is a member of the National PACE Association, which includes 72 PACE programs in 30 states. This organization helps to support the frail elderly who have complex health care needs and a strong desire to remain living in the community. Funded as a capitated system through per-enrollee payments from Medicare and Medicaid, it is able to manage these funds and fully coordinate the health care needs of its enrollees. The entrance requirements are that a recipient is over the age of 55, certified by the state to require nursing home care, and live in an area that is served by a PACE program (nearly all of Rhode Island qualifies). The integrated care consists of health care providers and social service providers, and includes all necessary services such as transportation and homemaker services for each patient. All services must be deemed medically necessary.

Home Health Care Agencies:

There are 59 licensed Home Nursing Care Agencies in the State of Rhode Island. Few of them are integrated with other health care entities, such as hospitals. These agencies will be important elements to the new value-based care system because they will serve as partners to primary care providers, hospitals and long term care institutions and provide important services in aiding patients as they transition between institutions, or back into their homes. Home health care and hospice agencies are also important to providing high quality end of life care. Like entities in other areas, such as independent hospitals, these agencies are expected to face pressure to consolidate and partner with institutions in the future.

Community-Based Organizations:

A number of Community Based Organizations provide services whose importance will only grow with the transition to the new value-based health care system. Some of these organizations already are well versed in issues such as patient privacy and outcome data collection, and others provide relevant services but are not fully coordinated across all care settings. Several of the most active organizations to date are listed below:

YMCA: The YMCA of Greater Providence includes seven different branches across the state. The YMCA has a number of health care services, including "Join 4 Me," a program aimed at helping overweight children and teenagers achieve a healthy weight; a Diabetes prevention program, which is aimed at those with rising risk and is paid for by one commercial insurance carrier (UnitedHealthCare); and the Livestrong program, which supports adult cancer survivors who have become deconditioned or chronically fatigued. There is a statewide alliance of YMCA's, which is moving toward the creation of a statewide health resource.

Health Leads: This is a Providence chapter of a local organization that helps connect patients to the basic resources they need to be healthy, such as nutrition, housing, or jobs. This chapter is based at Hasbro Hospital, and advocates work with both providers and patients to make them aware of the local resources available to patients. Providers write 'prescriptions' for needed community resources, and advocates then help patients get connected to those resources. Staffed by college students, the Health Leads program is one successful response to the awareness of the importance of paying attention to social determinants of health.

Community Action Rhode Island: There are nine Community Action Programs (CAP Agencies) that provide social service support for Rhode Island's poor. Many of these agencies provide services that both directly and indirectly support the health of their client base, such as case management services for elders and family members, lead poisoning case management, fall prevention programs for the elderly, housing assistance, heating assistance and an emergency food supply, to name a few.

Rhode Island Parent Information Network: (RIPIN): RIPIN is an organization dedicated to empowering Rhode Islanders through information, support and training, and has a significant

focus on health care. Among their recent programs are/were an intervention program designed at working with high ED utilizers on a case management basis, a pediatric practice enhancement project and peer-to-peer resources to help individuals navigate health insurance information and enrollment.

Employers: Self-funded large employer groups make up 43% of the commercial insurance market (Office of the Health Insurance Commissioner of the State of Rhode Island, 2013)**.** Changes to the health care market in Rhode Island will need the support of this group of employers. According to the Graham Report referenced earlier, the top ten employers in 2010 in Rhode Island were private:

TABLE 4: LARGEST EMPLOYERS IN RI

Employer	Number of Employees in Rhode Island
Rhode Island State Government	14,904
Lifespan	11,869
The United States Government	11,581
The Roman Catholic Dioceses of Providence	6,200
Care New England	5,953
CVS Corp	5,800
Citizens Financial Group (Royal Bank of Scotland)	5,800
Brown University	4,800
Stop and Shop Supermarket Co. (Royal Ahold)	3,632
Bank of America	3,500

Other Members of the Health Care Community:

There are numerous organizations that provide support to the health care systems in Rhode Island. Other major organizations that have a significant impact on care delivery in Rhode Island include the Rhode Island Quality Institute (RIQI), which is the state's not-for-profit designated entity for Health information exchange and serves as the State's regional Extension center, and Healthcentric Advisors, the State's Quality Improvement Organization (QIO), which supports the provider community.

Rhode Island Quality Institute (RIQI): Founded in 2001, RIQI is a non-profit organization whose mission is to "significantly improve the quality, safety and value of health care in Rhode Island." Serving as a home for the Beacon Community Program, the Rhode Island Regional Extension Program Rhode Island's HIE, "CurrentCare," RIQI is dedicated to the development of quality health information that is available to patients, providers, payers and government. RIQI's Board of Directors is composed of representation from the rest of the local health care community, including hospitals, consumer groups and academia.

Healthcentric Advisors: With 18 years of experience, Healthcentric Advisors is a local nonprofit organization providing health care quality improvement patient safety technical assistance, analytical, educational, research, and project management services. The organization has a history of working with and for state and federal government agencies, health care providers, research organizations and other national and community entities. Healthcentric Advisors is known for its subject matter expertise in physician office practice transformation, care transitions and readmissions reduction, and making providers' quality data meaningful and actionable. A principal role for Healthcentric Advisors is serving as the Medicare Quality Improvement Organization contractor for the State of Rhode Island. The organization is viewed as one of the State's neutral conveners and assists health care providers in all settings to successfully implement new quality improvement initiatives. Its voluntary board of directors has representation from the health care, business, and consumer communities.

Insurance Coverage

The population of uninsured in Rhode Island (12.1%) is lower than the national average (15.8%). Additionally, Rhode Island's rate of uninsurance for children under 19 is 5.9%, well below the national average of 9.6%. Rhode Island enjoys a relatively high rate of employer-sponsored insurance coverage at 60%, and also has a large share of its non-elderly population on Medicaid (20%) (Urban Institute, 2012). The forthcoming Medicaid expansion is expected to enroll an additional 38,000 Rhode Islanders (Center on Budget and Policy Priorities, 2012), and an additional number of the uninsured will receive coverage through purchasing insurance through the Exchange, HealthSourceRI, with coverage effective in 2014.

Insurance Market:

There are four companies in the private commercial market in Rhode Island: Blue Cross Blue Shield of Rhode Island (BCBSRI), United Healthcare, Tufts Health Plan and Neighborhood Health Plan of Rhode Island (NHPRI). Combined, they cover 556,903 lives, as of December 2012, which represents a decline in number of commercially covered lives since 2011 (Office of the Health Insurance Commissioner of the State of Rhode Island, 2013). On average, since 2005, the enrollment in private market insurance has dropped 1.6% annually. This decline has been attributed to the lasting effects of the economic downturn and increase in the proportion of part-time or non-benefit jobs.

Most Rhode Islanders receive health insurance through their employers. Self-funded and fully-insured large employer groups make up 84% of the total insured market (43% and 41% respectively.) Fully-insured small group (13%) and fully-insured individual subscribers (3%) are the remainder of the market (Office of the Health Insurance Commissioner of the State of Rhode Island, 2013).

Blue Cross Blue Shield of Rhode Island (BCBSRI) currently maintains the market majority of commercial lives at about 70% in the state. United Healthcare of New England has approximately 27 % of the

market, and Tufts Health Plan has approximately 2.5% of the insured market (Office of the Health Insurance Commissioner of the State of Rhode Island, 2013).

Insurance Driven Reforms

Since 2009, there has been a multi-payer effort to support the development of Patient Centered Medical Homes (PCMH's) through the Chronic Sustainability Initiative of Rhode Island (see below for further description). BCBSRI, NHPRI and UHC have all been engaged in supporting this advance in the delivery of primary care.

In 2013, BCBSRI signed a contract with Rhode Island Primary Care Physicians Corporation to establish a Patient Centered Medical Home (PCMH) program or Medical Home. Through the program, BCBSRI pays physicians additional monthly fees to actively manage complex chronically ill patients; it has also invested in nurse managers on the primary care team. The goal of the project is to provide a better model of care focused on prevention and chronic care management and to improve health outcomes for patients. This effort has supported a number of Rhode Island primary care practices in the achievement of medical home development.

BCBSRI also partnered with South County Hospital to create a 'Medical Neighborhood' (Blue Cross and Blue Shield of Rhode Island, 2013). This model involves the participation of independently practicing physicians, but relies upon the hospital to be the central support staff that is typically found in a Medical Home. BCBSRI is also engaged with South County Hospital with a bundled payment model for orthopedics procedures (South County Hospital , 2013).

United Healthcare of New England announced, in February of 2013, that they were forming an "accountable coordinated care organization" (ACCO), which includes Lifespan's acute care hospitals and physicians who will provide coordinated care to approximately 21,000 people in the state who are enrolled in United Healthcare's employer-sponsored benefit plans. This model is focused on managing patients with chronic diseases, and paying participating providers incentives based on process and clinical outcome measures. (UnitedHealthCare, 2013)

United HealthCare currently acts as a third-party administrator for the State of Rhode Island employee health insurance, a contract that expires at the end of 2013.

Neighborhood Health Plan of Rhode Island (NHPRI) is a locally based, not-for-profit health plan founded by the Community Health Centers of Rhode Island in 1993, in response to the initiation of RIte Care, the Rhode Island Medicaid managed care program. Using a network model, it offers coverage to four distinct Medicaid populations: families with low to moderate income, children with special health care needs, all children in the Rhode Island foster care system and Medicaid-only adults. At the end of 2013, it became the larger of two providers for the Integrated Care Initiative, which is a program designed to coordinate care for the Medicare and Medicaid dual eligible population. Currently, NHPRI covers approximately 66% of all Medicaid managed care recipients in Rhode Island and 50% of all Medicaid enrollees in Rhode Island. Over 90,000 individuals are enrolled in their programs. Starting in 2014,

NHPRI will offer coverage in the individual and small employer market through HealthSourceRI, the state's health insurance exchange.

Tufts Health Plan has a small but growing presence in Rhode Island. They have been focusing on providing support to employers through the provision of robust wellness plans and are the only health plan in the Northeast to be awarded NCQA Wellness & Health Promotion Accreditation (Tufts Health Plan, 2013). They are considered leaders in the Massachusetts market and are expected to continue this work in Rhode Island when they offer plans on HealthSourceRI beginning in 2015.

Health-Related Agencies in the State of Rhode Island

There are a number of state agencies that work together to address the health needs of the residents of Rhode Island. The Executive Office of Health and Human Services houses the state's Medicaid program and provides fiscal and management oversight of four state departments including the Department of Health (RIDOH), Department of Human Services (DHS), the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) and the Department of Children, Youth and Families (DCYF). While the Department of Health (RIDOH) falls under the umbrella of EOHHS, it is the only public health agency for the state and is critical to assuring that transforming the health care system serves both individuals as well the entire population of RI. HealthSourceRI is Rhode Island's state-based Health Insurance Exchange. The Office of the Health Insurance Commissioner (OHIC) is the regulatory agency overseeing all commercial health insurance, including consumer and provider issues regarding insurance. Finally, the Lieutenant Governor's office functions as a key convener and leader of coordinated health care reform efforts. The work of other agencies, such as the Division of Planning within the Department of Administration, the Department of Transportation and the Department of Environmental Management also affects the health of Rhode Islanders. The Department of Administration also plays a key role in its management of state employees and retirees health benefits. The following is a summary of the key health-related roles and responsibilities of the five departments/offices listed above:

TABLE 5: RI AGENCY RESPONSIBILITIES

Agency/Office	Primary Responsibilities
Department of Health	Public health, licensing providers and facilities, Health Services Council, Inspections
Executive Office of Health and Human Services / Medicaid	Medicaid policy and program management
Office of Health Insurance Commissioner	Commercial health insurance regulation
Department of Behavioral Health, Developmental Disabilities and Hospitals	State hospitals, Behavioral health and substance abuse programs and chronic long term medical and psychiatric conditions

HealthSourceRI	Health Insurance Exchange for individuals and small businesses

Medicaid

OVERVIEW

During State Fiscal Year(SFY) 2012, Rhode Island's Medicaid program served approximately 228,000 Rhode Islanders, with an average of 193,000 enrolled at any one time. Twenty-two percent of Rhode Island's population were enrolled in Medicaid for some part of SFY 2012 and program expenditures totaled approximately $1,783 million. Medicaid expenditure is divided among several state agencies, with $1,369 million of total expenditure managed by the Office of Health and Human Services (OHHS), and $366 million managed by the Department of Behavioral Health Care, Developmental Disability and Hospitals (BHDDH).

Under the Medicaid program, the federal government is typically responsible for approximately half of total expenditure. In SFY 2012, the Federal Medical Assistance Percentage (FMAP) was 52.33%.

Between 2008 and 2012, total Rhode Island Medicaid medical expenditures based on date of service have increased an average of 1.3 percent per year. This overall expenditure increase is associated with a 2.2 percent average annual increase in enrollment combined with a 0.9 percent overall average decrease in per member per month (PMPM) costs. The increase in enrollment and the decrease in PMPM can be added together to determine average annual expenditure growth.

Enrollment declined from 2007 through 2009, but then increased in 2010, exceeding 2007 levels, and continued to increase in SFY 2011 and 2012. PMPM costs increased from SFY 2008-2010 and then decreased in SFY 2011 and 2012 to lower than 2008 levels, resulting in the negative average annual trend. These expenditure trends compare quite favorably to both national Medicaid expenditures and state commercial per member per month cost trends.

POPULATIONS SERVED

Medicaid serves four different primary populations, each with very different service needs and PMPM cost experience.

- Adults with disabilities account for the largest share of expenditure, with 2012 expenditure of $662 million, and an average PMPM cost of $1,808. The largest components of expenditure for this population are residential and rehabilitation services for persons with developmental disabilities (26%) and hospital care (25%).
- Elders account for $476 million in total 2012 Medicaid expenditure, and the highest average cost per member per month (PMPM) of $2,230. For this population, nursing facilities account for roughly two-thirds (65%) of expenditures.
- Children and families account for 69% of total enrollment and 27% of total expenditure, with total 2012 expenditure of $474 million. Additionally, the federal match is increased to 66.63%

for qualifying "optional" low income children and pregnant women under the Children's Health Insurance Program (CHIP).

- Children with special health care needs (CSHCN) account for 10 percent of total Medicaid expenditures and 6 percent of enrollees, with total 2012 expenditures of $170 million. Expenditures on this population are dominated by professional behavioral health services, which account for just under half (44%) of total expenditures.

MEDICAID PROVIDERS

Medicaid pays for services offered by a variety of providers. Hospitals and nursing facilities together account for nearly half (46%) of program expenditure. Key contributors to expenditure growth were hospitals and professional providers.

- Hospitals were the largest provider type, accounting for 27% of Medicaid expenditure in 2012. Hospital payments are also a key driver of Medicaid expenditure growth, as payments to hospitals increased by an average of 4.0% per year between 2008-2012.
- Nursing facilities were the next largest provider type, accounting for 19% of expenditure in 2012. Expenditure on these providers has been increasing on average 2.0% per year between 2008-2012.

MANAGED CARE

It is important to note that not all payments are made directly by Medicaid to service providers. Seventy-seven percent of Medicaid eligibles are now enrolled in managed care plans. These enrolled populations account for 49% of Medicaid expenditure.

- Children and families who are not eligible for employer-sponsored or Medicare coverage are nearly all enrolled in managed care plans.
- Starting in 2008, children with special health care needs, without other insurance coverage were required to enroll in managed care plans, resulting in 79% of this population now enrolled in managed care. In addition new managed care programs were established in 2008 to transition Medicaid eligible adults with disabilities to managed care. In 2012 47% of adults with disabilities were enrolled in managed care.
- Rhode Island's participating Medicaid Managed Care Health Plans have consistently ranked among the nation's top performing Health Plans according to commonly used Healthcare Effectiveness Data and Information Set (HEDIS®) measures.

COMMUNITY CARE AND LONG TERM CARE

Expenditure on community care and long term care accounts for about 41% of total Medicaid expenditure ($724 million) in SFY 2012. Community care programs are intended to allow states to provide home and community based services to at-risk populations as alternatives to more costly nursing home/institutional options.

MANDATORY AND OPTIONAL SERVICES

Most of the expenditure on optional services is designed to reduce expenditure for mandatory services. Optional services accounted for $507 Million in total Medicaid expenditure in SFY 2012, approximately 28% of total Medicaid expenditures. The largest component of optional services is residential and rehabilitation services for persons with developmental disabilities, including group homes. These services provide an important alternative to more expensive (mandatory) inpatient/institutional services for persons with developmental disabilities.

HIGH COST USERS

Medicaid expenditures are highly concentrated, as the top 7% of users account for nearly two- thirds (66%) of expenditures.

- High cost users are defined as those who incur $25,000 or more per year in Medicaid expenditure. These high utilizers typically present with multiple, complex conditions, requiring care coordination across a variety of provider types. This suggests a sustained need for care management, focused on high cost/chronically-ill populations.
- Eighty-three percent of expenditure for high cost users is for Elders and Adults with Disabilities. The largest categories of expenditure for high cost users are nursing facilities and residential and rehabilitation facilities for persons with developmental disabilities.

UTILIZATION

Individuals covered by both Medicare and Medicaid have dual coverage ("duals"). Medicare is the primary payer for most medical services (e.g. hospital, physician, pharmacy) for 96% of elders and for 48% of adults with disabilities. Medicaid pays for services not paid for by Medicare (e.g. extended nursing home stays, home and community supports). For "non-duals" (persons covered only by Medicaid), Medicaid pays for all covered services.

- For dually-covered elders, nursing home admissions increased 2% per year on average between SFY 2010 and 2012 while hospice admissions per thousand decreased by 2% per year on average. Also, nursing home admissions are five times higher than hospice admissions per thousand.
- Emergency room visits and inpatient admissions per thousand for adults with disabilities covered only by Medicaid are relatively flat over SFY 2010-2012 while office visits per thousand have increased 5% per year on average.
- For children and families and for children with special health care needs, acute care utilization measures, such as inpatient admissions, emergency room (ER) admissions, and office visits, have decreased since 2010.

Health Care Information and Technology in Rhode Island

Rhode Island's state government has been a leader in creating the information and technology backbone that will continue to support the State's transition to value-based care. The following section

outlines the State's progress in Electronic Health Record (EHR) adoption, the Health Information Exchange state's integrated child health information system which includes the state's immunization registry(functions like a pediatric public health HIE) the All Payer Claims Database (APCD), the Unified Health Infrastructure Project (UHIP) and the Chronic Care Sustainability project (CSI).

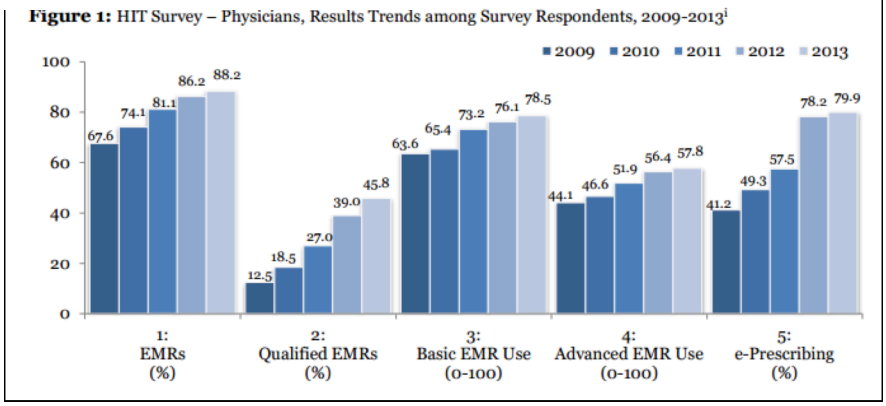
ELECTRONIC HEALTH RECORD (EHR) ADOPTION

Rhode Island has valued the use of health information technology and continues to see progress in the adoption of electronic health records. The Department of Health has been measuring the level of adoption through an annual HUT survey since 2009, well before the HITECH act and CMS Meaningful Use Incentive Program .

In early 2013, the Rhode Island Department of Health administered its fifth annual HIT survey to 3,799 physicians licensed in Rhode Island, in active practice, and located in Rhode Island, Connecticut or Massachusetts. The response rate was 62.3% (n=2,367) (Rhode Island Department of Health, 2013). While the EHR adoption rate of survey respondents is 88%, when normalized to the entire physician population the HER adoption rate stands at approximately 51%.

The following table from the Department of Health's survey demonstrates an ongoing trend of providers adopting EHRS.

FIGURE 2: DOH HIT SURVEY 2013



Importantly, in 2010, Rhode Island received a total of $27 million from the American Recovery and Reinvestment Act (ARRA) in the form of three grants (HIE, REC, and Beacon community) to the Rhode Island Quality Institute for investments in Health Information Technology. $6 million went to the creation and funding of the Regional Extension Center (REC) designed to assist providers with EHR

implementation and achieving Meaningful Use. Through the REC, primary care providers receive support and assistance in EHR adoption, implementation and reaching meaningful use. The REC serves as a trusted advisor, helping to "bridge the technology gap." The REC assists providers as they select and EHR vendor, undertake workflow analysis to support implementation and reach meaningful use. Additionally, the RI REC established a vendor market place that is comprised of pre-qualified EHR software vendors, technical service consultants and health information service providers (HISPs, needed to support Direct messaging). The REC helps providers assess vendor options, and makes cost and functionality comparisons to simplify the vendor decision-making process. RIQI has also leveraged the Regional Extension Center staff of relationship managers to educate, recruit and train providers on several HIT programs and services, including Currentcare (the state's HIE), Direct messaging and promoting Health IT certification for health care professionals. More specifically the REC staff works closely with their HIE and other RIQI colleagues to promote the following:

- CurrentCare Services – The RI REC staff promotes and recruits provider offices to engage in CurrentCare (including getting provider offices to enroll their patients in Currentcare, encourage providers to use the Currentcare viewer, obtain a direct messaging account and subscribe to the hospital alerts service.

- Direct messaging – Direct messaging is secure email for transmitting patients' protected health information (PHI). It allows for provider-to-provider communication, enables providers to receive Hospital Alerts from Currentcare when a patient is admitted to a hospital or emergency department and enables providers to send clinical care document summaries to Currentcare for their enrolled patients

- Health IT Certification training - The RI REC is one of just four Regional Extension Centers that have partnered with Health IT Certification, LLC to provide training in four professional certification programs, including: Electronic Health Records, Health Information Technology, Health Information Exchange, and Operating Rules Administration (Rhode Island Quality Institute).

HEALTH INFORMATION EXCHANGE

Rhode Island's Health Information Exchange, Currentcare, was initially created in 2004 through a AHRQ grant to the Department of Health in partnership with RIQI. In 2008, RIQI was designated by the state as its Regional Health Information Exchange organization and began to build operational capacity to oversee the management and operations of the statewide HIE. In addition to the operations of Currentcare, in 2010, RIQI received $5.3 million in ARRA grants focusing on "implementing an integrated information exchange to improve health outcomes, reduce medical errors, and make our health care delivery system more effective and efficient" (Rhode Island Quality Institute, 2010). Currentcare is structured as an opt-in centralized HIE service where patients choose to have all of their information shared to create a longitudinal health care record (across health care entities) and available to designated health care providers. Specifically, when patients agree to have their information become part of CurrentCare

(enroll), they also choose one of three options that outline the criteria in which providers can access their data: 1) all of their treating providers, 2) only those providers specifically named and in an emergency or 3) only in an emergency.

As of the end of December 2013, RIQI has enrolled 349,000 individuals (35% of the states population) in Currentcare. There are multiple health care organizations that are now contributing data on enrolled patients to current care, including ten hospitals sending ADT feeds, seven hospitals sending laboratory data (three more expected by end of year), two large clinical laboratories, 28 Medical practices (33 expected by end of year), two community mental health centers, seven large chain pharmacies and one large diagnostic imaging center for reports (MRI, CT, XRAY, US).

Additionally, the patient opt-in requirements have prompted private market initiatives centered around increasing the enrollment of Rhode Islanders in CurrentCare. In September 2013, BlueCross BlueShield of Rhode Island and RIQI released information on their joint incentive program for providers to assist in increasing patient enrollment. "Under the incentive program, eligible providers (those in family practice, pediatrics or internal medicine who are in compliance with BCBSRI's EHR Payment Policy) may receive up to $10,000 in incentives per practice if they sufficiently enroll their patients and utilize current cares services, described below:

- CurrentCare enrollment –To qualify for incentives, PCP practices must enroll the greater of the following: at least 200 patients per affiliated PCP or enroll a number of patients, equivalent to at least 50 percent of their BCBSRI members.

- Use of the CurrentCare Viewer and Hospital Alerts—PCP practices can qualify for additional incentive if at least 75% of the staff is trained to use the online portal known as CurrentCare Viewer and the practice enables CurrentCare Hospital Alerts. The Currentcare alerts uses hospital admission, discharge and transfer data to notify a provider that their patient has been admitted to or discharged from the emergency department or hospital.

- Implementation of a Direct Messaging Account—This allows for secure electronic communication between providers that use different electronic medical record systems" (Rhode Island Quality Institute, 2013) and is the transport method for Currentcare to send hospital alerts and for providers EHRs to send clinical care documents (clinical summary data from an encounter) to Currentcare.

BEACON COMMUNITY COOPERATIVE AGREEMENT

In 2010, this program provided $15,914,787 over three years to the State of Rhode Island as part of a demonstration of how health IT investments and Meaningful Use of EHR's can support the movement toward patient-centered care (The Office of the National Coordinator for Health Information Technology, 2012). Rhode Island was one of 17 recipients of funds to support the efforts to strengthen the use of IT in health care. According to the program website, the key areas of focus for these projects were:

1. Building and strengthening the health IT infrastructure and exchange capabilities within communities, positioning each community to pursue a new level of sustainable health care quality and efficiency over the coming years;
2. Translating investments in health IT to measureable improvements in cost, quality and population health, and
3. Developing innovative approaches to performance measurement, technology and care delivery to accelerate evidence generation for new approaches.

The Beacon Communities Projects, as implemented in Rhode Island was coordinated by RIQI.

KIDSNET

The Rhode Island Department of Health maintains a separate health information database for its pediatric population called KIDSNET. KIDSNET is Rhode Island's computerized child health information system designed to serve families, pediatric providers, and public health programs. Operational since January 1, 1997. KIDSNET captures information on all children born in the state, as well as from children born out of state who see a Rhode Island participating providers or receive services from a program participating in KIDSNET (Rhode Island Department of Health, 2013).

Focused on screenings and ensuring that children receive the right preventive care at the right time, KIDSNET collects information from:

- Birth Records
- Immunization information from health care providers that immunize children
- Laboratory reports from Newborn Bloodspot
- WIC (Special Supplemental Nutrition Program for Women, Infants and Children)
- Healthy Homes and Childhood Lead Poisoning Prevention Program
- Early Intervention
- Newborn Developmental Risk Assessment
- Rhode Island Hearing Assessment Program & audiologists
- First Connections Program (home visiting)
- Birth Defects Program (Rhode Island Department of Health, 2013)

Providers can use the KIDSNET web portal to look up any of the above information on their patient. It is important to note since KIDSNET is a public health program, it includes data on all children and does not require individuals to opt-in as Currentcare does. Additionally, discussions are underway as to how to best integrate KIDSNET data with Currentcare data and minimize a provider's need to log into both systems.

ALL PAYER CLAIMS DATABASE

Rhode Island is building an All Payer Claims Database (APCD) as a partnership initiative administered by a state government interagency workgroup which includes the Department of Health (DOH), Executive Office of Health and Human Services (EOHHS), the Office of the Health Insurance Commissioner (OHIC), and the HealthSourceRI. The APCD will allow for:

- Longitudinal tracking of individuals across insurance carriers at the individual provider level;
- Robust reporting and analysis to aid and improve the calculation of risk scores;
- Measuring utilization and spending;

At the time of submission, a data submitter workgroup reviewed and finalized the technical specifications and operationalization of the ACPD. These regulations were finalized and include strong privacy protections for consumer data, including the need for a data review board. Additionally, the interagency group hired, through RFP processes, several vendors to build and operate the APCD. The vendors currently under contract include:

- Freedman Healthcare: project management vendor
- Onpoint Health Data: data aggregator responsible for preliminary data intake and collection, data structure and format checks, creating person level extract
- Arcadia solutions: (as a subcontractor to Onpoint) Encrypted Unique Identifier Vendor responsible for creating unique IDs for patients, attaching payer's eligibility files, and returning data to payers

Additionally the interagency workgroup issued a Request for Information (RFI) to inform the state how to best structure the data, analytic and hosting needs of the APCD. Based on that information, the IWG is developing an RFP that will be issued in Jan 2014 to select a vendor to perform these tasks.

TRAILBLAZERS

Organized by the State Health Information Exchange Program in the Office of the National Coordinator for Health Information Exchanges, the Trailblazer program is an effort to align Healthcare Information Technology with Health Care Reform Efforts. Rhode Island joined these efforts in Phase 2, in November 2012. Through this program, states are studying the best approaches to the collection of data and how to harmonize measures across providers and payers. Also of concern is reporting, and how to ensure that such data actually support improvements in day-to-day delivery of care. According to the program website, infrastructure will be developed to advance five critical goals:

1. Measure state progress in furthering the triple aim of better care, better health, and lower costs.
2. Use validated performance measures to reward providers through payment reform.
3. Use provider-level performance data to strengthen quality improvement initiatives by offering timely and comprehensive feedback.
4. Reduce the reporting burden through a streamlined, electronic data gathering system.

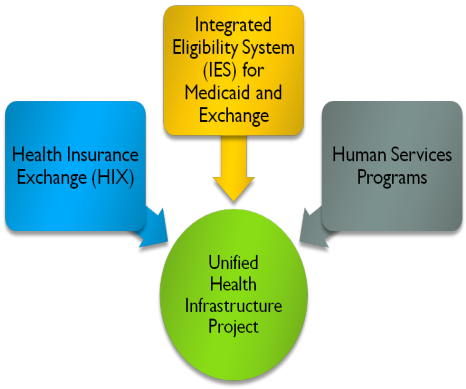
5. Develop models (e.g., action plan templates) that other states can adopt when building quality improvement infrastructure.

UNIFIED HEALTH INFRASTRUCTURE PROJECT:

In recognition of the need for increased interoperability, Rhode Island created the Unified Health Infrastructure Project (UHIP) designed to be a single technical platform that will support the Health Benefits Exchange, Medicaid eligibility, and other state human service program eligibility. UHIP serves as a centralized resource for additional health information deemed necessary and appropriate. UHIP is an interagency initiative between HealthSourceRI, Executive Office of Health and Human Services (EOHHS), and the Office of the Health Insurance Commissioner (OHIC).

At the time of submission, the technical vendor for UHIP was chosen (Deloitte); user testing complete, functionality approved, and initial deployment occurred on October 1, 2013. The initial phase included information on HealthSourceRI and Medicaid (RIteCare) eligibility for the expanded population. Outreach and communication around HealthSourceRI and Medicaid expansion are underway via mass media and targeted marketing approaches. The state is in the final stages of creating a plan for metrics and evaluation around the continued use of UHIP. The state intends to incorporate publically reported quality measures in order to assist individuals with the purchase of insurance and the choice of a provider.

FIGURE 3: UHIP FUNCTIONS



History of Health Care Reform in Rhode Island

The State of Rhode Island has long been a leader in efforts to reform health care as a means to improving the health of its citizens. Even prior to 2010, when the Patient Protection and Affordable Care Act (ACA) was passed, Rhode Island had made a number of bold steps toward achieving the triple aim of better care for individuals, better health for populations and reducing per-capita costs.

Rhode Island's modern day efforts at systemic health reform started in the early 1990s when the state undertook an effort to move parts of its Medicaid population to managed care. The RIte Care program was initially created for low-income children up to 250% of the Federal Poverty Level (FPL), but expanded to Medicaid eligible parents (185% FPL) in 1998 with care delivered through an HMO network. As a result of this expansion, the number of uninsured Rhode Islanders decreased to 6.9% in 1999, the lowest uninsured rate in the country at the time. In 2000, legislation created the RIte Share Program that provides state premium assistance to families eligible for Medicaid with access to employer sponsored health insurance. The RI Department of Human Services was given the power to implement the program and public funds from CHIP, Medicaid and state dollars were used to subsidize the employer-sponsored insurance premiums for all eligible RIte Care participants who had access to such employer coverage. Today, RIte Care offers coverage to not only children and parents, but also to pregnant women (250% FPL). Participants can choose from 2 innovative managed care programs from either Neighborhood Health Plan of RI or UnitedHealthcare. The RIte Care and RIte Share programs cover roughly 120,000 Rhode Islanders.

In 2005, Rhode Island created the Executive Office of Health and Human Services (EOHHS) as a coordinating entity for those state departments that impact the publically-funded health care system. After legislation passed in 2006, EOHHS became a state agency led by the cabinet-level Secretary of Health and Human Services. EOHHS coordinates the fiscal matters, legal needs and policy direction of the Department of Health (RIDOH), Department of Human Services (DHS), the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) and the Department of Children, Youth and Families (DCYF). In 2009, EOHHS was designated as the single state agency for Medicaid.

With strong interest in using policy levers to ensure that its citizens receive quality care at affordable prices, the state established the Office of the Health Insurance Commissioner (OHIC) in 2004, through legislative action in the General Assembly. OHIC is the first state agency in the nation that has a commissioner that is dedicated solely to health insurance oversight. Moreover, the Rhode Island legislature expanded the traditional role for insurance regulation beyond consumer protections and insurer solvency, to access and affordability and into such areas as mandated spending levels and the requiring of price transparency. Such a role, laid out in the OHIC *Purposes Statute* balances traditional regulation with policy development. The directive for the Office is laid out below:

a. Guard the solvency of health insurers;

b. Protect the interests of consumers;

c. Encourage fair treatment of health care providers;

d. Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and

e. View the health care system as a comprehensive entity and encourage and direct insurers toward policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

Since its inception, OHIC has introduced several key pieces of regulatory reform that have directly impacted the health of Rhode Islanders, notably the Affordability Standards and their associated requirements for primary care investments.

The Affordability Standards were created in 2009 and implemented in 2010. This is a set of criteria that directs commercial health insurance issuers with significant market share in Rhode Island. Together, these criteria are aimed at improving the affordability and quality of health care in Rhode Island. Specifically, the Affordability Standards require issuers to:

1. Expand and improve primary care infrastructure
2. Spread the adoption of the patient-centered medical home
3. Support CurrentCare, the state's health information exchange
4. Work toward comprehensive payment reform across the delivery system

In the first Affordability Standard, OHIC established requirements for primary care investment to facilitate delivery system reform in Rhode Island. The standard requires insurers improve the state's primary care infrastructure by increasing the share of total medical payments made to primary care by one percentage point per year from 2010 to 2014. The insurers are forbidden from passing these increases onto employers through higher premiums. OHIC also sets the percentage of primary care spending that must be paid through means other than fee for service rate increases. This is an example of the transparency that Office of the Health Insurance Commissioner has the authority to encourage, monitor, and enforce.

The Rhode Island Chronic Care Sustainability Initiative (CSI-RI) is a collaborative, all-payer PCMH effort of over 45 practices and 14 Community Health Centers that date back to 2008 when it was initially established by the Office of the Health Insurance Commissioner. Today it provides care to 250,000 Rhode Islanders. This program includes the largest payers in the state: Blue Cross and Blue Shield of Rhode Island (BCBSRI), Medicaid, Neighborhood Health Plan of Rhode Island (NHPRI) and United Healthcare of New England and Medicare. All of the payers in CSI-RI agree to pay a per-member, per-month fee for care coordination, as well as pay for the services of a care management nurse (Robeznieks, 2008). Payment rates are tied to achievement of clinical quality, utilization and process improvement targets. Early results from the program show that CSI patients had lower inpatient stays than a comparison group of non-CSI patients (for the first five years of the program). However, while CSI patients overall had a higher number of ED visits than a comparison group of non CSI patients, there is a downward trend in ED visits per 1000 member months over the first five years of the program. The comparison group shows an upward trend. (Rosenthal, Friedberg, Singer, Eastman, Li, & Schneider, 2013)

In the Spring of 2010, Elizabeth Roberts, the Lieutenant Governor, established a 150-member Healthy RI Task Force to determine how Rhode Island could best respond to the opportunities and challenges presented by the ACA. This volunteer task force was made up of a broad range of stakeholders that

ultimately became the foundation for the recent SIM design workgroup membership: hospitals, payers, providers, community activists and others. Their tasks were to look at such possible reforms in the areas of the insurance market coverage and expansion, opportunities in long term care, workforce development issues, payment realignment and delivery system reform, prevention and to begin to lay the foundation for the State's Health Insurance Exchange. The group issued a report in September of 2010 that presented the findings and recommendations of that Task Force.

Upon being elected Governor in November 2010, Lincoln Chafee established a Rhode Island Healthcare Reform Commission. As soon as he took office, he appointed Lieutenant Governor Roberts as its Chair. With its Executive Order, the Commission is directed to "address specific issues in health care reform, including but not limited to implementation of national reforms under the federal Affordable Care Act." The Commission established seven workgroups: exchange development, payment and delivery reforms, data and evaluation, workforce needs, policy and legal issues, communication and outreach, and long term care. To coordinate the activities, there is an Executive Committee within the Commission, which reports regularly to the Governor with specific recommendations.

The Governor formed Rhode Island's Health Insurance Exchange, HealthSourceRI, as a result of an additional Executive Order. Since this time, Rhode Island has been committed in its efforts to establish a public health insurance exchange, and is notable in that it achieved many of the required steps as one of the first states to do so. For example, the state was the first in the nation to receive a Level II Exchange Establishment Award from the federal government as a result of its bids for a planning grant and level one establishment award (Urban Institute, 2012). HealthSourceRI opened successfully on October 1, 2013.

The Director of HealthSourceRI is committed to its development as a tool to continue to push for reform in the State. Integrated into HealthSourceRI is a "one-stop" enrollment opportunity for residents to enroll in State Programs for which they meet eligibility, and the Director's ultimate plan is to use the site to publish quality data on each of the payers and their effectiveness at reaching specific population health goals. The State looks forward to the long term development of the Exchange and views its launch as a key moment of health care reform in Rhode Island history.

The State has been a leader in the efforts to expand Medicaid, which it first began in the 1990s when it raised the coverage levels to children and parents up to 250 and 175 percent of the federal poverty level, respectively (Urban Institute, 2012).

Rhode Island also has a long history in health prevention and wellness efforts. The Department of Health (RIDOH) is the only government public health entity in the state; the counties do not have local departments. RIDOH has numerous programs that seek to promote population health and to reduce the disparities in health by focusing on healthy child development and the prevention of disease and disability. RIDOH has provided leadership in many areas for the development of this SHIP, including establishing a model of community health workers with its Certified Diabetes Outpatient Program and its use of Certified Diabetes Outpatient Educators (CDOEs). RIDOH also supports a Family/Peer Resource Specialists program to support the needs of primary and specialty providers. Over 300 providers

reached out to this program in 2012 (Rhode Island Department of Health, 2013). The RIDOH also supports efforts to reduce racial and ethnic health disparities. In the past, RIDOH was able to support Minority Health Promotion Centers that addressed health needs of minority communities. Although there are no county health departments, some of the cities, notably Providence and Warwick, have staff who focus on improving health in the community.

Current Federally Supported Programs in the State, including existing demonstrations and waivers granted by CMS:

Rhode Island's health care system currently operates with the support of a number of federal programs, both within and outside of Centers for Medicare and Medicaid Innovation (CMMI). These programs serve as the foundation of the innovations that will continue to transform and improve Rhode Island's health care in the coming years.

Current CMMI Projects and Awards

Health Care Innovation Awards: These are three-year grants that are provided to organizations to implement new ideas in order to deliver better care to Medicare, Medicaid and the Children's Health Insurance Program CHIP recipients. The RI recipients are presently: Health Resources in Action, Women and Infants Hospital, and the University of Rhode Island.

> *From CMMI website:*
>
> *The Health Care Innovation Awards are funding up to $1 billion in awards to organizations that are implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the highest health care needs.*
>
> *The Health Care Innovation Awards Round Two are funding up to $1 billion in awards and evaluation to applicants across the country that test new payment and service delivery models that will deliver better care and lower costs for Medicare, Medicaid, and/or CHIP enrollees.*

FQHC Advanced Primary Care Practice*:* East Bay Family Health, Thundermist Health Center of Warwick and WellOne Primary Medical and Dental Care all are in their first year of funding for this PCMH demonstration project.

> *From CMMI Website:*
>
> *The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice demonstration will show how the patient-centered medical home model can improve quality of care, promote better health, and lower costs*
>
> *This demonstration project, operated by the Centers for Medicare and Medicaid Services (CMS) in partnership with the Health Resources Services Administration (HRSA), will test the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for up to 195,000 Medicare patients.*

Participating FQHCs are expected to achieve Level 3 patient-centered medical home recognition, help patients manage chronic conditions, as well as actively coordinate care for patients. To help participating FQHCs make these investments in patient care and infrastructure, they will be paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services. In return, FQHCs agree to adopt care coordination practices that are recognized by the National Committee for Quality Assurance (NCQA).

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Bundled Payments: Kent Hospital, Newport Hospital, Rhode Island Hospital, The Miriam Hospital and multiple home health agencies are operating with Bundled Payment Models Two and Three, in which payments are structured around an episode of care (Two: Acute and Post Acute, Three: Post Acute Episode Only.)

From CMMI website:

Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care at a lower cost to Medicare.

In Model 2, the episode of care will include the inpatient stay in the acute care hospital and all related services during the episode. The episode will end either 30, 60, or 90 days after hospital discharge. Participants can select up to 48 different clinical condition episodes.

For Model 3, the episode of care will be triggered by an acute care hospital stay and will begin at initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long term care hospital or home health agency. The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and will end either a minimum of 30, 60, or 90 days after the initiation of the episode. Participants can select up to 48 different clinical condition episodes.

Community-based Care Transitions Program: Carelink, Inc. was awarded the Community-based Care Transitions Program (CCTP) from CMS under the Innovation Center. Carelink is in partnership with Lifespan's Rhode Island Hospital and Miriam Hospital, as well as Chartercare's Roger Williams Hospital and Our Lady of Fatima Hospital to target four diagnoses (CHF, COPD, MI and PENU) and improve the transition experience of discharged patients.

From CMMI Website:

The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program.

Advanced Payment ACO Model: This is composed of physician-based and rural providers that volunteer to provide coordinated Medicare delivery. Coastal Medical, the largest primary care group in Rhode Island, is participating in this effort.

From CMMI Website:

The Advance Payment Model is designed for physician-based and rural providers who have come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Through the Advance Payment ACO Model, selected participants will receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure.

State-wide CMMI Awards

Multi-Payer Advanced Primary Care Practice: Under this demonstration, fee-for-service Medicare joined the state-based "Chronic Care Sustainability Initiative" multi-payer medical home demonstration. RI is one of eight states chosen to participate in this unique state-federal partnership, where CMS agreed to join multi-payer demonstrations based on state-designed payment and delivery system reforms.

From CMMI Website:

Under this demonstration, CMS will participate in multi-payer reform initiatives that are currently being conducted by states to make advanced primary care practices more broadly available. The demonstration will evaluate whether advanced primary care practice will reduce unjustified utilization and expenditures, improve the safety, effectiveness, timeliness, and efficiency of health care, increase patient decision-making and increase the availability and delivery of care in underserved areas.

Medicaid Emergency Psychiatric Demonstration: This is a test for Medicaid's ability to reimburse private psychiatric hospitals for services that were previously not reimbursable.

From CMMI Website:

The Medicaid Emergency Psychiatric Demonstration was established under Section 2707 of the Affordable Care Act to test whether Medicaid programs can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain services for which Medicaid reimbursement has historically been unavailable.

This demonstration will provide up to $75 million in federal Medicaid matching funds over three years to enable private psychiatric hospitals, also known as IMDs, to receive Medicaid reimbursement for treatment of psychiatric emergencies, described as suicidal or homicidal thoughts or gestures, provided to Medicaid enrollees aged 21 to 64 who have an acute need for treatment. Historically, Medicaid has not paid IMDs for these services without an admission to an acute care hospital first.

Other Federally Supported Health Care Reform Efforts in Rhode Island

Medicaid 1115 Waiver: Rhode Island recently submitted an extension request to its current 1115 Waiver. The original waiver allowed Rhode Island to operate the entire Medicaid program under a single 1115 demonstration. The RI Medicaid Reform Act of 2008 directed the State to apply for a "global" demonstration under the authority of Section 1115(a) of Title XIX of the Social Security Act. The Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration (*1115 Waiver*) established a new Federal-State agreement that provides the State with substantially greater flexibility than is available under existing program guidelines. The State has used the additional flexibility afforded by the 1115 Waiver to redesign the State's Medicaid program to provide cost-effective services that will ensure beneficiaries receive the appropriate services in the least restrictive and most appropriate setting.

The 1115 Waiver has three major program goals: to re-balance the publicly funded long term care system, to ensure all Medicaid beneficiaries have access to a medical home and to implement payment and purchasing strategies that ensure a sustainable, cost-effective program.

The 1115 Waiver savings fell short of promised levels, in part because the State realized that many of the elderly Medicaid recipients who could have been eligible to be transferred out of long term care facilities did not have safe, community-based housing to return to. The State recently submitted an extension request with a specific focus on enabling funds to be used to support housing.

Medicaid Health Homes: Although CMS financial support recently ended, Rhode Island continues to support two of these Medicaid innovative complex care delivery models; one is for the pediatric population and builds upon a pre-existing program called Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation (CEDARR). The other is an adult focused program that is for the serious and persistent mentally ill population. The adult program is managed by Community Mental Health Organizations. According to CMS, health homes are designed to serve Medicaid enrollees who meet one of the following criteria (Centers for Medicare and Medicaid Services, 2010):

- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

Early data suggests that families using the CEDARR program have an improved quality of life.

Money Follows the Person (MFP): In April 2011, a Money Follows the Person demonstration grant was awarded to Rhode Island. This five year, $27 million grant provides Rhode Island with support to achieve its goal of rebalancing the long term care systems. The goals are to support the transition of individuals out of long term care facilities and back into their home through the use of improved home and community-based services as well as to eliminate the barriers and mechanisms in state laws, state Medicaid plans or state budgets that prevent or restrict the flexible use of Medicaid funds.

Medicaid Adult Quality Measures Grant: This is a two-year grant designed to help state Medicaid agencies develop staff skills and capacity to collect, report and analyze data on the Initial Core Set of

Health Care Quality Measures for Adults Enrolled in Medicaid (Centers for Medicare and Medicaid Services, 2013). Rhode Island is one of twenty-six states awarded this five-year grant.

Integrated Care Initiative (Commonly referred to as the "Duals Initiative"): This is a federal alignment initiative to better coordinate care for those individuals who are eligible for both Medicare and Medicaid. CMS has offered funding in order to test two models for States to improve the alignment between the financing of these two programs and integrate primary, acute, behavioral health and long term services and supports for their Medicare-Medicaid enrollees. One is a fully capitated model and the other is a managed fee-for-service model.

In keeping with Rhode Island's desire to quickly implement those health care reforms that are expected to result in the highest quality care while decreasing the growth in cost, it has chosen the capitated care model for its 35,707 dual-eligible recipients. Three entities are participating in the Duals Initiative in Rhode Island: Neighborhood Health Plan of Rhode Island, which has long been a managed care payer for Medicaid, PACE, which has used a capitated approach to coordinate care since its inception in 2005 in Rhode Island and Rhody Health Partners, which manages care through a primary care medical home.

Safe Transitions Program: Managed by Healthcentric Advisors, the Safe Transitions Program is underway as a competitive Medicare Quality Improvement Organization effort. It was designed to decrease patient re-admission rates and therefore, Medicare expenditures, by coaching patients to better self-manage their care and by improving patient/provider communications.

D. THE BASIS FOR CHANGING RHODE ISLAND'S HEATLH CARE SYSTEM

During the course of Rhode Island's State Innovation Model Design Process, the current system of care in Rhode Island was examined and discussed. Specifically, the current model of care was evaluated against the vision of a new system of care, one that provides lifelong support of health and wellness, a focus on population health, coordinated models of care and payment transformation. A number of deficits in the current model of care were identified, both through review of data sources and in the 54 interviews with Rhode Island health care stakeholders conducted as part of the design process.

1. **Current fee for service environment does not support population health, leads to higher unnecessary or inappropriate utilization and does not promote coordinated care delivery.**

Most commercial insurance dollars in health care are spent in a fee-for-service manner (Rhode Island Office of the Health Insurance Commissioner, 2012). It is widely acknowledged that a fee-for-service payment methodology does not create incentives for providers to support the whole health of their patients, nor does it encourage or support coordination to maximize efficiency and quality for all care that a patient receives. Fee-for-service also neglects the patient's need for navigation among and between the patchwork of providers that support their health. (Wallack & Thompkins, 2003)

2. The system of care delivery is fragmented, which can lead to overutilization and higher costs.

In Rhode Island, there are a high number of independent practitioners and an insufficient infrastructure to coordinate and manage care across providers and health care systems. Physicians and other providers have few incentives and limited ability to follow patients as they proceed to specialists or change health care settings, such as transitioning back to the home after a rehabilitation stay in a long term care facility.

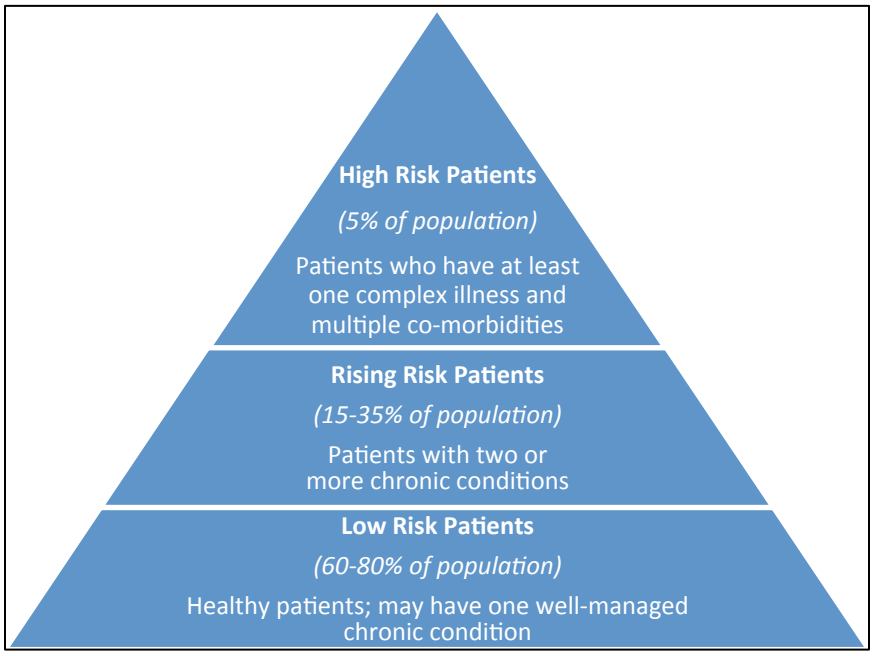
3. Current practice of care transitions increase vulnerability of readmissions/reduced adherence to evidence-based procedures, poorer health outcomes (all of which contribute unnecessary costs)

Care transitions, such as those from hospital to home or from a hospital to a long term care facility increase the vulnerability for risky events in the life of a patient. Poorly executed, they can diminish health and drive up costs (Health Affairs, 2012). Care plans must be understood by and communicated across caregivers. For vulnerable populations, such as the elderly, a poorly managed transition can result in a poor patient experience and outcome as well as an expensive and unnecessary readmission. These potential poor outcomes lead to higher costs and higher rates of morbidity and mortality for the patients. As the payment system pressures lengths and classifications of hospital stays, supportive and successful care transitions becomes much more challenging.

4. **The highest risk (top 5%) population is costly due to multiple co-morbidities and requiring a high intensity of services.**

Rhode Island has conceptualized its population health as being comprised of three groups: High Risk, Rising Risk and Low Risk. (See Figure 4)

FIGURE 4:



The populations with the highest levels of illness are responsible for a disproportionate amount of health care spending. For example, according to a Milliman actuarial analysis, in 2012 the top 1% of health care utilizers represented 29% of total spend for commercial, 23% for Medicaid and 13% for Medicare.

5. **Many Rhode Islanders in the population referred to as the "Rising Risk" population (those with one or two chronic conditions) receive uncoordinated and disparate preventive care that leaves them vulnerable to higher costs and in danger of rising to the high-risk category**. **Similarly, the low risk population has low engagement with the health care system due to their relative good health.**

The rising risk group represents about 15% of the population and the remainder fall in the low risk category. Without successful education, change in lifestyle and prevention efforts, the rising and low risk populations will move up the scale at the same or increased current rate due to behavioral patterns such as smoking or over-eating if no interventions are made.

6. **Rhode Island is concerned about the prevalence of mental illness and substance abuse, as well as the high cost of treating these conditions**.

Behavioral Health diagnoses appear in the top three highest diagnoses across Medicare, Medicaid, and commercial payers. Accordingly, behavioral health diagnoses represent significant costs to the health system.

The statewide community health needs assessment report provides additional empirical support to the widely acknowledged problem of Rhode Islanders having higher than average mental health illness (Hospital Association of Rhode Island, 2013). For example, Rhode Island residents were more likely to report "one or more days of poor physical or mental health in the previous month" than were residents across the nation. Looking specifically at substance abuse, Rhode Island ranks 35th in the nation on binge drinking measures (United Health Foundation, 2012) and roughly 48% of Rhode Island adults report smoking at least 100 cigarettes in their lifetime which is above the US figure (44.8%). Among Rhode Island residents who are still smoking, 63.2% have attempted to quit in the last year, which is also higher than the US average, indicating a motivated population to improve its health.

7. **Lack of consistent transparency among providers and payers inhibits consumers from selecting care based on value**.

There is no formal, reliable, centralized approach to inform consumers, payers or providers as to the cost and quality of health care services in Rhode Island. Furthermore, there is no ability to compare providers across the state. As consumers share more and more of the health care burden, transparency of cost and quality information becomes critical to the decision process.

8. **There are unrealized opportunities for the health care system to incent higher levels of patient engagement**.

Years of experience within fee-for-service structures have taught patients that their health care is something that can only be understood and managed by physicians. The stakeholder interviews conducted as part of the design of this state Health Innovation Plan (SHIP) revealed that there are many areas in which health care providers and payers will soon be expecting patients to take a higher responsibility for managing their own health and health care choices. Given the relative lack of familiarity with the delivery system for the average patient, this raises concerns that Rhode Island residents may not yet be fully ready to take on these responsibilities.

9. **Community-based organizations are unevenly equipped to participate in health care and are poorly coordinated with the areas of greatest need**.

The variation in ability to collect and analyze data, among community groups, became apparent during the hours of discussion with community-based organization representatives during the SIM Model Design efforts. If community-based organizations are going to be expected to support patients and

providers in their efforts to pursue healthy lifestyles and/or obtain needed social supports, then many of these organizations need to have more sophisticated tools and knowledge to support the tracking of patient outcomes.

10. The current health care system allocates few resources to incorporating social determinants of health into the care delivery and payment system.

It is known that it is the basics of social life that have the greatest impact upon the health of individuals. Influences on a person's life such as housing, access to nutrition, and safe neighborhoods are critical in the efforts of individuals to live healthy lives. Unfortunately, due to years of cost-cutting and political disagreement, the state has not had the ability to make significant investments in these areas.

Rhode Island understands that the social determinants of health affect the health of its population. Its housing stock is old, and according to the state Consolidated Plan, as of 2008, the median age of for the housing stock in the state was 1956. Over a third of the stock was built before 1939, which places it second in the nation for older housing, behind Massachusetts. Older housing carries significant health threats, especially when lower income families occupy these homes. This housing stock is directly related to the elevated rates of Childhood Lead Poisoning and asthma that plague residents of Rhode Island.

Additionally, the social environment can be challenging for Rhode Islanders in that the unemployment rate remains high (at time of this writing, it has the second highest unemployment rate in the nation), and the rate of single parent households is among the highest in the nation, at 34.8%. Furthermore, the percentage of people over the age of 65 that live alone is at 31.1%, which is also higher than the national average of slightly less than 30%. (Hospital Association of Rhode Island, 2013)

Ten percent of adults older than 65 live in poverty, compared to the national median of 8.4%. (Hospital Association of Rhode Island, 2013)

11. **Data show that there are disparities between groups, e.g., Medicaid and commercially insured populations**

One key disparity is that Rhode Islanders between the ages of 18 and 64 who are on Medicaid and/or Medicare (Dual Eligibles) have higher rates of chronic diseases, such as a diabetes rate of 15% compared to 5% for those with private insurance. Risk factors are also higher for the publically funded groups: 32% of Rhode Islanders on Medicaid smoke, compared to 13% for those with private insurance; and obesity rates are higher among the Medicaid population as well, at 36% compared to 25% for the privately insured population.

12. **Community Health Workers under-recognized**:

Despite the successful program at the Rhode Island Department of Health, in the marketplace that is considering new forms of value-based care, the definition of "Community Health Worker" remains unclear. Furthermore, awareness of the existence of this specialty and function is low among providers.

13. **Limited knowledge of how the current and future health care workforce is prepared to provide care in a value-based system (both in training and in availability)**

As the health care system has created structures and reforms to move away from fee-for-service in the past decade, there had been a recognized need for new types of health care workers. Rhode Island has seen the advent of Community Health Workers, Nurse Care Managers and Health Analytics Specialists. The state does not have current or complete data on its health care workforce, its training level or its distribution within the system. Additionally, the state does not have a forecasted demand for workforce needs under a system of population health management and coordinated care models.

14. **Uneven expectations and knowledge around value-based care practices**

As value-based care is still a relatively young concept in the planning efforts in Rhode Island, it appears that provider education programs are incorporating some of its principles into curricula at different rates and with different foci, if at all. The result is that providers are entering the workforce with different understanding of what's needed in a new system. Many providers that have participated in the SHIP Design process have reported frustration with their employees or colleagues in that they lack necessary skills for this new method of practicing health care.

15. **Populations with complex or specialized health care needs face ad hoc, non-standard or marginal care structures.**

Rhode Island's health care system has had varied levels of success in addressing the health care of persons with complex or specialized needs. Certain structures to address specific populations were created auxiliary to the traditional system. Others were created as alternatives to the system, often from dedicated funding sources. Other health care needs are poorly addressed due to gaps in the system.

This section addresses some of the SHIP requirement D: Health System Design and Performance Objectives

E. RHODE ISLAND'S HEALTH CARE GOALS

Rhode Island aims to create a system of care that meets four key elements: lifelong support of health and wellness, a focus on population health, coordinated models of care and payment transformation. The purpose of this system would be to improve the health of Rhode Islanders, while at the same time "bending the cost curve" of health care in Rhode Island and improving the care experience for Rhode Islanders. By implementing the reforms outlined in this State Health Care Innovation Plan (SHIP), the state expects to achieve these goals across five years. A description of how Rhode Island would measure itself against these goals is included in the evaluation plan. (Section J)

Goal #1 Improve the Health of Rhode Islanders

The fundamental shift in the health care system away from episodic care and toward a population health orientation is done with the explicit goal of positively impacting the health of Rhode Islanders. There are three levels of measurement that can help Rhode Island understand its progress toward this goal. The first are measures that look at the indicators of overall health. An example of this is to examine, on a population-wide basis, Years of Potential Life Lost. The second level of measurement would look at the prevalence of specific diseases and conditions that contribute to a population's health. This might include the number of Rhode Islanders with Type II Diabetes per thousand residents or the number of Rhode Islanders with Body Mass Index (BMI) greater than or equal to 30. Finally, Rhode Island can measure behavioral and lifestyle indicators that impact the health of the population. These measures might include the number of Rhode Islanders that smoke and the age at which they began smoking and the number of Rhode Islanders that lead a sedentary lifestyle.

Goal #2 Improve the Quality of Health Care in Rhode Island

Quality and outcomes will be improved through the integration of primary care with community groups, hospitals and specialists. By building a robust analytic system at the individual and practice level, providers and payers will be supported in their efforts to deliver efficient and better-coordinated health care to Rhode Island residents.

Goal #3 Bend the "Cost Curve" of Health Care in Rhode Island

Through the transition to value-based care, it is also the goal of Rhode Island to slow the rate of growth of health care spending. Health care legislation passed in the General Assembly in early 2013 included the authorization to review Rhode Island's health system total cost of care, its drivers and to provide findings and recommendations.

Goal #4: **Transition to Value-Based Care**

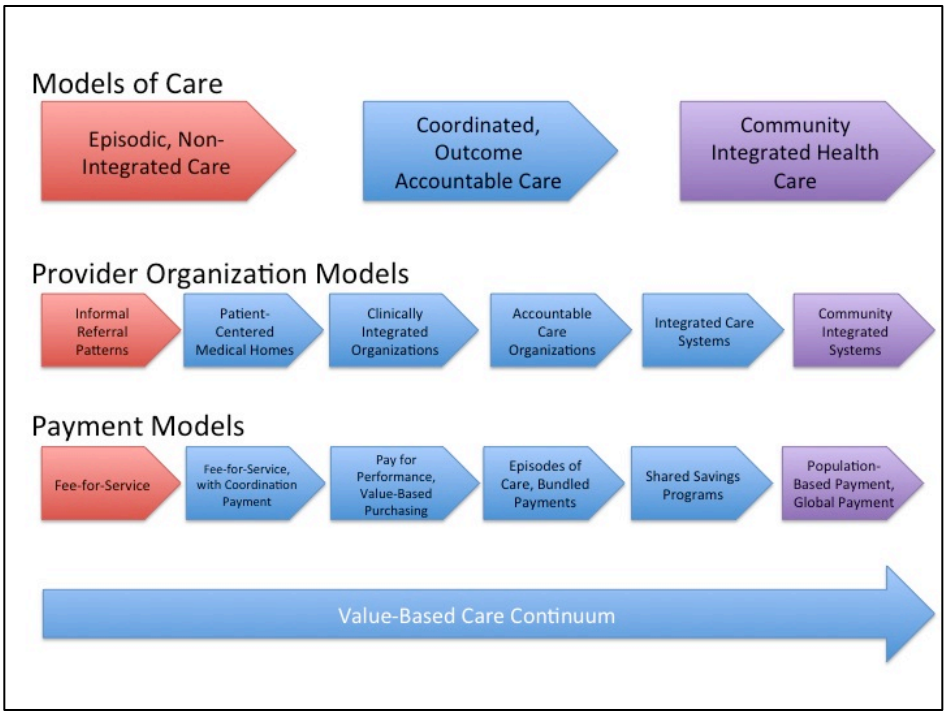
The system goal of the plan is to ensure that at least 80% of Rhode Islanders have access to care that functions in value-based care arrangements, building on PCMH's as a foundation and transitioning through CMS models of value based payment such as Pay for Performance, Bundled Payments, and Shared Savings. These models help develop provider capacity to bear shared financial responsibility.

F. RHODE ISLAND'S VALUE-BASED CARE PARADIGM

Rhode Island promotes a vision of a new system of care – one that supports lifelong health and has as its primary focus and goal, the health of the population of the state. This system is constructed on a foundation of a model of coordinated-care model, supported by a shift away from traditional fee-for-service payment models. While the plan does not specify a single coordinated care model with specific payment structures, there are characteristics that Rhode Island considers fundamental to value-based care.

Rhode Island considers the move to value-based care to be a fluid continuum, with both providers and payers starting at different points and moving at different paces toward the paradigm. The continuum construct speaks to the health care system on three levels – the model of care, the ways providers are organized, and the payment methods. Figure 1. Outlines the Value-Based Care Continuum.

Figure 1.



This value-based continuum is further defined by certain characteristics that are essential to the paradigm.

- **Population Health Management** – Fundamentally, the shift to value-based care is a shift in the health care system away from a primary orientation focused on providing care to treat instances of illness and injury to a primary orientation focused on keeping a population healthy. In order to make this critical realignment in the health system, there are a number of key evidence-based

strategies that provider organizations must engage. In general, Population Health Management consists of three key strategies**:**

- Empowering and enabling primary care providers to be the central coordinator of care
- Supplementing primary care with robust, patient-centered care management tools and resources based on a modernized data infrastructure
- Leveraging those care management tools and resources to effectively engage people in their own health.

The shift to population health management must be supported by effective provider relationships and a change in payment methods. Integral to a population health management orientation is a robust, scalable data infrastructure that supports both providers and patients. Finally, in a system that is oriented to population health, outcomes and measures must be clear, transparent, evidence-based and harmonized across payers.

- **Provider Relationships** – In a value-based system, providers must have formal relationships to coordinate the care of patients. For example, the patient-centered medical home model includes specific, formal arrangements for care coordination and other services through the medical home. Also, Clinically Integrated Organizations have formal agreements between providers, often between independent practice associations and hospitals or health systems. These agreements relate to the coordination of care and are often directly related to the payment models and arrangements with payers. Rhode Island's Value-Based Care Paradigm relies on such formal arrangements that can range from formal care coordination agreements to contractual partnership in a care organization, to corporate integration and aggregation.

- **Payment Models** – The Rhode Island Value-Based Care Paradigm eschews traditional fee-for-service in favor of a model that rewards outcomes rather than volume. There are a number of payment models that have been developed to replace traditional fee-for-service in a way that supports providers in working with patients to attain and maintain health, while preserving the system of care to treat illness and injury. These models take many varied structures:

    - Patient-centered medical homes receive a payment on top of traditional fee-for-service to provide care coordination and other care management services that have not always been reimbursed in the past.
    - Pay for performance models have been discussed for years, and recent Medicare changes, along with the advent of reporting systems made possible by electronic medical records, have brought these to greater maturity. Most pay-for-performance models hold back percentages of fee-for-service payments and pay back an amount less than, equal to or greater than the hold-back depending on results on pre-defined performance measures.
    - Bundled payments or episodes of care are payment models that pay a set amount for care of a specific diagnosis or treatment modality. Examples include bundled payment for maternity and normal delivery, or for a knee replacement. These bundled payments

would represent the only payment for care leading up to a procedure or event, and then related aftercare for recovery. In order to ensure quality and protect patients, bundled payments are often paired with process and outcome measures. Provider organizations that are able to provide the appropriate services under a bundled payment arrangement at a lower cost than the payment share the savings among providers.

- Shared savings programs represent a newer innovation in provider payments. Under shared savings, a provider is held accountable for the costs of an attributed population of patients. In general, a provider organization takes on the role of care coordination and management for a population of patients and responsibility for the overall costs of care for that population. If the patients attributed to that provider organization have a lower cost of care than projected, the payer and the provider organization share in the savings. This arrangement is sometimes referred to as upside risk. Some shared savings programs also include downside risk, in which a provider organization is responsible for reimbursing payers a portion of the costs over projections if the care for the patient groups exceeds projected costs. Medicare has implemented a shared savings program, as have a number of other payers in collaboration with provider organizations.
- Population-based payment, also referred to as global budgeting or global payment, is a payment method in which a provider organization receives a flat payment for the total care of a population of patients. The provider organization is then responsible for the provision of care under that population-based payment, in accordance with strict access and care quality requirements. Population-based payment, along with shared savings programs must include behavioral health payments in payment models. Ideally, the models should also include oral health payments.

- **Health Information Technology and Measurement** – Rhode Island's Value-Based Care Paradigm relies on robust health information technology as a necessary element of infrastructure. Multiple factors dictate this reliance on technology. First, providers require technology solutions to allow for effective coordination of care. When multiple providers are attempting to coordinate the care of an individual, technology that allows for information sharing and tracking of critical health factors is a necessity. Second, engaging patients in their health requires an effective patient interface, supported by technology. Third, payment models that are based on the costs of care for a population require provider organizations to understand and address the trends of the costs for their population. Finally, if payment models are also oriented to outcomes, technology systems that effectively and accurately record and report those outcomes are essential.

- **Outcomes Orientation** – Finally, the Rhode Island Value-Based Care Paradigm is rooted in the premise that value is derived from the outcomes attained by the health care system for the costs of provide care or supporting health. Therefore, any model of care in the value-based care paradigm must have an alignment and commitment to outcomes that match the needs and

objectives of the community. These outcomes should first address the health of Rhode Islanders and then the practices of the health care system. This prioritization would drive toward the vision of a health care system that supports the efforts to attain and maintain health in Rhode Island. The measures used to assess performance against the outcomes must be developed in a transparent manner, must be effective to determine performance, and must be harmonized across payers and providers.

G. INNOVATIONS TO ACHIEVE THE VALUE-BASED CARE PARADIGM

Rhode Island benefits greatly from the fact that a transition toward the value-based care paradigm is already underway. For nearly a decade, Rhode Island has been implementing efforts at both the provider level and the community-level to move away from the model of care that is episodic and non-integrated, with the pace of innovation increasing rapidly over the last 24 months. Even with this increase in efforts driving toward the value-based care paradigm, there is consensus that the complexity of changing the business model of the health care system requires further, concentrated effort to drive reform. This need for further effort is heighted given the variability in the readiness to adapt to the changing model of care.

Therefore, Rhode Island considers a number of policies and activities with purpose of simulating and fostering innovation to achieve the value-based care paradigm. These policies and activities fall broadly into five categories, though many could be classified in multiple categories. The categories are:

- Payment Transformation
- Delivery System Enhancements
- System Transition
- Health Information Technology and Measurement
- Population Health Efforts

It should also be noted that some of these efforts build upon each other, and build upon efforts that are already underway in Rhode Island.

PAYMENT TRANSFORMATION

Changing the model for payment for health care services is a fundamental step in achieving the value-based care paradigm. The creation of coordinated care models that support the health and wellness of the population rely on a move away from the traditional fee-for-service model of care. The following activities seek to use the regulatory and purchasing authority of the state to drive changes in how the health care system is paid for the care it provides.

Use regulatory and purchasing powers to set payment standards

Rhode Island has multiple opportunities to drive payment transformation through its regulatory and contracting authority. The Office of Health Insurance Commissioner (OHIC), through its statutory authority, has the ability to set specific standards relating to affordability and provider contracts. OHIC previously set spending targets for primary care for insurers in the fully insured market. In like manner, OHIC has the authority to require insurers under its jurisdiction to gradually increase, over a number of years, the percentage of its payments into care that is provided through the value-based care paradigm.

Additionally, the Executive Office of Health and Human Services, through the Medicaid program, has the authority to set standards for participation in the Medicaid managed care program. Any re-procurements of Medicaid managed care services could include a standard for a percentage of payments for care delivered under the value-based care paradigm. HealthSourceRI, which works with

OHIC to develop standards for Qualified Health Plans (QHP) to be offered for sale through HealthSourceRI, could also set phased-in targets for percentages of payments for care delivered under the value-based care paradigm.

Encourage value-based care options for state and municipal employees, and Medicaid fee-for-service members

Using the leverage of the state's role as a purchaser of employee insurance coverage, Rhode Island will incorporate the goals of the value-based paradigm to encourage new care options for state employees, municipal employees, early retirees and Medicaid recipients within a five-year time frame. Nearly all of Rhode Island's Medicaid population is under managed care. Medicaid can leverage the use of managed care to set targets for its managed care organizations to the amount of care delivered in a value-based care framework.

DELIVERY SYSTEM ENHANCEMENTS

The move away from episodic, non-integrated care cannot rely on payment changes alone. The current system of care exists with the support of the current payment system and a new system of care with new payment models will have different features. By supporting these features during the transition, the system of care can more easily evolve toward the model of coordinated, outcome accountable care. The following approaches are meant to accelerate the move to the value-based care paradigm by creating or supporting those necessary components of the new system of care.

Commit to full, statewide availability of Patient Centered Medical Homes (PCMH)

Building on the state's successful multi-payer demonstration, Rhode Island will expand the effort to ensure that every Rhode Islander that wishes to receive care in a Patient Centered Medical Home will have the ability to do so. In order to achieve this, Rhode Island will continue to support the Chronic Care Sustainability Initiative (CSI-RI), which is a program to support and expand Patient Centered Medical Homes in the state. There are already activities underway to support this initaitve. OHIC requires participants in the fully insured market in Rhode Island to honor the common contract developed to support Patient Centered Medical Homes. HealthSourceRI offers QHPs that are built around patient-centered medical homes, and provide incentives to purchasers to select these plans.

Pediatrics will be included in the expansion of Patient Centered Medical Homes. In fact, recent discussions in Rhode Island have suggested the development of services in a Patient Centered Medical Home geared specifically toward adolescents to account for specific care needs of persons 12-21 years of age. Developing a medical home relationship during adolescence may also support continued engagement in care and healthy activities in their 20s and 30s.

Additionally, the state will work with CSI-RI to involve specialists and hospitals in the PCMH coalition in order to support the "Medical Neighborhood" concept and maximize the opportunity to coordinate care and decrease unnecessary utilization**.** The Patient Centered Medical Home model has served in Rhode

Island and the nation as the foundation for integrating and coordinating care, improving accountability and setting the stage for succeeding in financial risk models.

Expanding the use of Community Health Teams (CHTs)

The expansion of Patient Centered Medical Homes, and the transition of providers to the value-based care paradigm will create the need for greater levels of coordination and care management in the community. Additionally, the increased focus on aiding Rhode Islanders in maintaining health and achieving health goals requires a structure to engage Rhode Islanders in these efforts. Rhode Island considers the creation of community health teams as instrumental in supporting this increased need for management and coordination. Drawing inspiration from Vermont's Blueprint for Health, Rhode Island will build off the success of CSI-RI's pilot CHTs in the Pawtucket and South County communities, and the state will incorporate the lessons gleaned from the evaluation of the pilots as it rolls out CHTs incrementally over five years.

The Role of the Community Health Team

Community Health Teams in Rhode Island will fill the vital role of care coordination and management outside of the clinical setting, in addition to serving to support the health of Rhode Islanders through health and wellness coaching and enabling connection to community-based services to support health. Initially, CHTs will focus on the needs of the high-risk and rising-risk populations. Effective care coordination, treatment follow-up and connection with community-based health resources are essential to improving the health of these populations while ensuring that patients received the right care, at the right time and in the right setting given the complexity of their health needs. Rhode Island is also considering specialized CHTs to focus on specific needs of persons with behavioral health needs in addition to other chronic diseases.

As the model matures, CHTs would grow into a common resource for primary care practices for the entire population. CHTs would be part of the fabric of a person's care, supporting the needs of patients in off-hours or with community supports and supporting healthier communities that benefit the health of all residents. The relationships that can be created between the CHT and persons in the community represents the best tool to engage Rhode Islanders in their health on an individual basis.

Community Health Team as PCMH Enabler

PCMH practices supporting the needs of their patients rely on staff and relationships with collaborating provider organizations to provide the coordinated and care management services that bring so much value to the patient. One challenge to scaling the PCMH model across the state is the high number of small practices. A practice with one or two providers would likely not have the patient volume to support the staff necessary to provide the wide range of services that a PCMH includes. Therefore, Rhode Island envisions CHTs as a resource to allow the expansion of PCMH model to these smaller practices.

Community Health Teams as Coordinated Care Model Enabler

The models of coordinated care under the value-based care paradigm indicate the need for effective communication and collaboration between providers and provider organizations that have a formal care coordination arrangement. CHTs represent an ideal model to play that coordination role for systems of care. CHTs would be a primary point of contact after a hospital discharge or working to align the care of a patient that needs the services of multiple specialists. Primary care providers could use CHTs as the extension of their care oversight and management. Accountable care organizations and integrated health care systems could deploy CHTs to address the needs of patients that are unable to get to offices for visits or who needs regular follow-ups to ensure treatment adherence.

Implementation of Community Health Teams in Rhode Island

The model that Rhode Island envisions for Community Health Teams is teams that are directly linked to a person's source of primary care. In Rhode Island, this would mean that some CHTs are exclusive to, and likely employed by a provider organization, such as a large primary care practice or an accountable care organization. Other CHTs would be shared resources, likely distributed regionally, and connected to a practice. It is not envisioned that CHTs would have geographic catchment areas that would determine their patient panel.

Community Health Teams would have a nurse as care manager and clinical coordinator. The teams would also have a stable of care professionals that could be enlisted given a patient's care needs. This stable of professionals may include, among others, licensed clinical social workers, nutritionists and dieticians, clinical pharmacists and diabetes educators. Supporting the team would be community health workers who specialize in navigating the health care, social service and community organization systems.

Community Health Teams also require specific activities and changes to be a viable part of Rhode Island's health system. First, payment systems must support CHT structures. The traditional fee-for-service model has lacked consistent funding for care coordination services. Additionally, CHTs can provide value in both direct patient contact and coordinating activities between providers. Therefore, CHTs must be funded outside of the fee-for-service model.

CHTs also require a robust technological solution to support their care coordination and management efforts. CHTs must know when a patient is referred to them, who that patient's providers are and what treatment or care plans are in place. This requires effective information sharing between the providers and CHTs, and the ability for CHTs to access real-time information on a patient's care. CHTs also require a robust resource to enable the connection of patients to community-based resources. Rhode Island has a model for this connection tool in Health Leads, a community organization discussed earlier in this report, as well as local Community Action Programs that work with at-risk families.

The lack of consistency between the structures in Rhode Island's health care system results in the need for a phasing in of Community Health Teams to achieve the envisioned model. Rhode Island will support transition-models of CHTs, including those based in hospitals, behavioral health providers and payers, while the system of care continues its transition toward the value-based care paradigm.

Intermediary services for high utilizers

Recognizing that many of the highest utilizers of the Emergency Departments (ED) and Medicaid services also have behavioral health or substance abuse conditions, Rhode Island will continue develop a series of intermediate intensity services for the highest ED utilizers. Rhode Island's Medicaid program has implemented "Communities of Care," which identifies high end ED utilizers, offers them a progressive array of case management services (medical, behavioral and/or peer navigation) and tracks utilization before and after enrollment to assess the impact of the interventions on utilization patterns.

Other services may include Sobering Centers, Home-based primary care and "Ambulatory ICU's" for high-need patients. These patient-centric interventions offer the benefit of providing the high intensity support and services that this population needs in a more appropriate, lower-cost setting. Additionally, Rhode Island will develop and use Commnuity Health Teams in key areas to support Medicaid and Medicare high utilizers. Data shows that Medicaid populations tend to have higher incidence of chronic conditions and concentration of ED visits, these specialized managers will include clinical specialists in the areas of ED visit reduction, behavioral health, substance abuse, chronic conditions and pre-natal care.

Improve integration of community-based groups with primary care teams

Rhode Island will encourage and support the integration of community-based organizations into the health care system. Traditionally, community-based organizations have operated outside of and ancillary to the medical care system, despite the evidence that many of these organizations have effective and cost-efficient programs to improve health. The value-based care paradigm relies on the integration of community- based organizations into care plans to support the health of the population.

Using Community Health Teams as a coordinator, community-based organizations will become resources for primary care practices in their efforts to support and promote healthy lifestyles, and/or to provide access to basic supports such as housing and job training to fill deficiencies due to social determinants of health. Rhode Island seeks to build upon its community assets rather than creating new structures or organizations. Many of the community-based groups in the state have been working successfully for many years; Rhode Island would best be served by these organizations taking larger leadership roles in our community in efforts to improve residents' health.

Navigators and System Ombudsman

This new value-based care system represents a significant change in structure and will therefore be unfamiliar to most patients and consumers. Building off of the anticipated successes of the HealthSourceRI navigator program, and in concert with Community Health Teams, Rhode Island will make sure that there are accessible and knowledgeable support workers available to patients and consumers to assist them with their health needs, especially in navigating the system of care delivery. Additionally, an agency or entity will be identified to monitor the effectiveness and ease of navigation of the system, from the point of view of the patient, and work to identify areas that may need

improvement. This Systems Ombudsman will take on that responsibility and ensure that areas of difficulty within the system are addressed.

Behavioral Health System Reform

Rhode Island's fragmented system of behavioral health care and segmented sources of funding for that care makes reform in this system even more challenging. Layering in Rhode Island's higher than average rate of behavioral health diagnosis, any reform efforts must support the care needs of the population, The fundamental goal of delivery system reform in behavioral health is effective, meaningful integration with the other parts of the system of care resulting in improved health. This integration is a complex and challenging effort that many states are grappling with. The following strategies will help to facilitate integration, but Rhode Island recognizes that true integration is an ongoing objective that will require continued attention of policy-makers and stakeholders.

- **Payment Transformation:** One critical step to integration is the inclusion of behavioral health payments in coordinated and integrated payment models. This will demand the inclusion of behavioral health in coordinated care models under the value-based paradigm.

- **Co-Location of Behavioral Health and Primary Care:** Rhode Island is already utilizing a dual model of co-locating services as an initial step toward integration.
    - **Co-Location Strategy #1:** Rhode Island will expand the co-location of behavioral health providers at Primary Care delivery sites and screen regularly for behavioral health problems. This intervention is most effective for those with a lower level of acuity in their behavioral health diagnosis. Rhode Island will encourage screening and referral through the leverage of requiring process and outcome measures as part of the payment transformation to value-based contracting. Screening measures including PHQ-9 and SBIRT do not require a medical doctor for test administration, so this approach will not adversely impact the already heavy burden on primary care physician workflow. This is a significant step in integrating care and using care managers appropriately in a team-based approach to primary care
    - **Co-location Strategy #2: Co-locate Primary Care Providers at Community Mental Health Clinics.** Building on the success of a number of efforts already underway, including the Health Homes project, Rhode Island recognizes that a crucial improvement tool to increase access to primary care for patients with behavioral health diagnoses is to bring primary care to the locations where populations who suffer from more acute needs are already located. This population is also likely suffering from chronic illness, and has a significantly shorter life expectancy as a result of many factors – but particularly due to ack of regular access to primary care (Merides, 2013). This is a patient-centric solution that acknowledges that such patients face many obstacles in their efforts to obtain basic health care, and by solving at least some of them, Rhode Island can improve their quality of life.

- **Community Health Teams:** As discussed earlier, the structure of Community Health Teams is designed to provide effective coordination and care management between providers. Using CHTs to support and coordinate behavioral health, including the use of specialized, behavioral health focused CHTs will support efforts for integration.

SYSTEM TRANSITION

Effectively moving from the current model of care to the value-based care paradigm will require significant work. Even with payment transformation and delivery system enhancements, the shifting of care models for health care providers will require hands-on assistance. Additionally, the size, distribution and skill set of Rhode Island's health care workforce is critically important. A health care workforce that is not in the right setting, or not the right size, or lacking the skills needed to support the value-based care paradigm will prevent the new model of care from succeeding.

The Rhode Island Care Transformation and Innovation Center

The Rhode Island Care Transformation and Innovation Center (RICTIC) is a concept that will accelerate Rhode Island's transition to value-based care. It is a public-private partnership that will assist Rhode Island's health care system transition to the value-based care paradigm by hosting and supporting convenings and collaboratives, by providing technical assistance to health care providers and community-based organizations, and by providing seed funding to organizations as they seek to move toward the value-based care paradigm.

Rhode Islanders that participated in Healthy Rhode Island and other reform efforts voiced a clear need for coordinated technical assistance in the shift to value-based care. For example, the March 2012 report of the Payment and Delivery System Reform Workgroup of the Rhode Island Healthcare Commission stated:

> Providers must be assisted in the transition to any new models. At all levels, providers need transitional guidance, and potentially investment, to move from the current system to any new payment or delivery model. That assistance could be a ramping up of implementation or technical assistance in changing practice or operational models to ensure success in a new system (Rhode Island Healthcare Reform Commission, 2012).

The RICTIC will coordinate and offer guidance for providers in the transition to coordinated care models. Rhode Island recognizes that the RICTIC can build on several of these efforts – described below – that are already under way. The RICTIC will ensure these current and future technical assistance initiatives help practices meet the characteristics of the Rhode Island value-based care paradigm.

Selected Care Transformation Efforts Underway

Use of Health IT in Practices - As the Medicare Quality Improvement Organization for the State of Rhode Island, Healthcentric Advisors began working with some of the first practices in the state to implement Electronic Health Records and integrate them into existing clinical processes with *The Doctors' Office Quality Information Technology* (DOQ-IT) program. Healthcentric followed DOQ-IT with two additional EHR / Health IT quality improvement contracts for physician offices that supported early adopters of advanced quality endeavors and practices struggling with the pace of change.

In 2008, Healthcentric partnered with physicians to improve preventive health outcomes by helping them interpret and use clinical quality measures via consistent data capture, interpretive analytics, and electronic clinical decision supports. Healthcentric Advisors most recent physician office quality contract, which began in 2012 and is called *Improving the Health for Populations and Communities,* focuses on advanced EHR use, care team transformation, and patient engagement. Examples of their technical assistance include:

- Harmonizing project quality improvement measures such as:
    - Meaningful Use
    - Physician Quality Reporting System (PQRS)
    - Healthy People 2020
    - The ABCs of the Million Hearts Campaign
    - NCQA PCMH Standards
- Capturing, reporting and analyzing EHR data to identify trends and outcomes, and redesign workflows
- Promoting peer-networks, direct electronic messages and provider compacts between PCPs and specialists to support broad patient management
- Promotion of EHRs as a tool for patient education and visit summaries

Care Transitions -Healthcentric Advisors has worked with health care providers and other community organizations since 2008 to improve transitions of care for Rhode Islanders and reduce avoidable hospital readmissions through education, research, and technical assistance.

Healthcentric Advisors' Safe Transitions program supports individual providers who use evidence-based interventions to reduce hospital readmissions. The program has also formed regional coalitions that identify ways to improve transitions in their community. Safe Transitions also established Best Practice Measures for different settings to create measurable, community-wide standards for patient and provider communication.

These regional coalitions have demonstrated meaningful success. For example, CMS recognized one of the five coalitions, Washington County, for achieving a top Relative Improvement Rate (RIR) in readmissions per 1,000 Medicare fee-for-services beneficiaries. In late 2013, Healthcentric Advisors began expanding Safe Transition to an EOHHS-funded learning collaborative. This collaborative identifies communication opportunities between hospitals and community providers at the time of discharge.

Patient Centered Medical Homes (PCMH) – The two large PCMH projects in Rhode Island – Blue Cross Blue Shield's PCMH and the state's Chronic Care Sustainability Initiative (CSI-RI), offer a formal and successful structure for coordinated care led by primary care teams.

CSI-RI is Rhode Island's multi-payer Patient-Centered Medical Home demonstration project. The project has helped primary care practices reach NCQA standards for patient-centered medical homes through an all-payer, collaborative approach. CSI began with five primary care practices that wanted to change for all their patients, not just for one insurer at a time, and needed help doing so. Today, CSI includes 38 practices that care for approximately 200,000 patients. Together, these practices share ideas, communicate openly, experiment, and used evidence-based techniques to change the way they interact with patients, particularly those with chronic conditions.

CSI partners with BCBSRI's provider relations team and other technical assistance providers to offer formal practice transformation to all its member practices. These ongoing sessions, led by experts, reinforce and troubleshoot the PCMH model with more experienced sites and train new practices in team-based care. CSI-RI sites must also hire a nurse care manager, which is funded by the program, to ensure there is an employee dedicated to implementing these transformation lessons.

BCBSRI's proprietary PCMH is similar to CSI-RI and funds additional elements such as physician champions and advanced quality measures. Similar to CSI-RI, the BCBSRI PCMH offers practice transformation and on-site case management and reports improved patient experience (patient *and* physician), outcomes, and spending trends. Because of their efforts, CSI-RI and BCBSRI PCMH practices provide higher-quality care and help their patients achieve better outcomes, such as fewer hospital admissions and readmissions.

In both cases, care transformation in Rhode Island centers on true collaboration among payers, providers and the state. Practices commit additional time for physicians, nurse care managers and other staff to attend regular internal and project-wide meetings. These gatherings help the project deepen its competencies by sharing best practices, developing new ways to care for patients, and agreeing to what outcomes the practices will be held. This collaborative model is transparent to all practices and lends well to expansion efforts to new practices.

Proposed Structure and Activities

Major Activities

The RICTIC will be a hub of innovation for Rhode Island's health care system, and will lead transformation through three main functions: (1) Convening of the Accountable Care Collaborative, (2) Technical assistance for practice transformation and analytics and (3) Funding and capital pooling for transformative interventions. The RICTIC will promote care transformation, lead collaboration, share best practices, and provide training and technical assistance to reorient the delivery system towards population health and value-based care.

In the short term (0-3 years), the RICTIC will convene and assist providers in the move to value-based care. As Rhode Island's health care system transforms (likely beginning in year 2), the RICTIC will begin focusing on the population health alignment of the delivery system. This work will likely include training on techniques to promote healthy habits for patients, use of Health IT to identify patients at-risk of chronic diseases and provide targeted interventions, and coordination of efforts between health care providers and community-based organizations that support the health of communities. The activities envisioned for the RICTIC are meant to use, and build upon, similar or supporting activities already underway.

Convening – As the innovation center of the state's delivery system, the RICTIC will serve as the convener of providers and policy makers. A core convening activity for the RICTIC will be the coordination of the Accountable Care Collaborative. The goal of RICTIC's role at the center of care transformation is to promote evidence-based and actionable proposals. Additionally, the RICTIC will host learning collaboratives focused on elements of the Rhode Island Value-Based Care Paradigm. These collaboratives will include training on effective use of HIT in a collaborative care model. These techniques break down the silos that exist between care systems, such as between behavioral health and oral health, and better integrate the community-based organizations into primary and acute care plans.

- ***Coordinated care collaborative:*** The RICTIC will establish and support a multi-stakeholder collaborative to support and foster provider organizations to move toward the coordinated care models identified in the value-based care paradigm. The collaborative will address the analytical, financial and strategic complexities of shifting the business model of provider organizations away from episodic, non-integrated care to coordinated, accountable care. Key activities of the collaborative would be to develop contract strategies, measurement strategies and shared learning for provider organizations. This coalition will also be instrumental in further identifying appropriate policy and/or regulatory changes that may be needed in the future.

  A collaborative structure is the same strategy used by the Office of Health Insurance Commissioner when it successfully sought to encourage the creation of Patient Centered Medical Homes. Market stakeholders have clearly articulated their desire for the state to retain its role as a convener as it seeks to implement health care reform in this state. Bringing together such a group as a multi-payer coalition will help drive accountability with payers and providers.

Technical Assistance – One challenge to Rhode Island's move to a value-based care paradigm is the readiness of providers to adopt and launch new care models and payment systems with their existing resources and training. The RICTIC will coordinate existing and future envisioned technical assistance efforts. Technical assistance may include: training in team-based population health management using electronic health records; developing systems for tracking patients and coordinating care plans with various providers; and incorporating techniques for shifting away from the fee-for-service mentality and engaging regularly with patients to monitor and maintain health. Assistance may also include training on how to use practice-based technology to meet outcome standards for payment systems.

Since providers across the state are in very different stages of readiness to move to the value-based care paradigm, the RICTIC must develop effective evaluation techniques to understand where a given provider is in regards to preparedness to transition to value-based care models.

Funding Activities – The RICTIC, given its administrative structure outlined below as well as its focus on innovation, is an ideal arrangement to organize and pool capital investment in Rhode Island's health care provider system. The RICTIC will serve a grant-making role for provider, payers and community-based transformation activities.

The transition to value-based care implies some transition costs. Previous transformation efforts have offered some level of financial support, such as the transition to electronic medical records under the American Recovery and Reinvestment Act and the Advanced Payment ACO project funded by the Center for Medicare and Medicaid Innovation. Rhode Island envisions the RICTIC as the source of such capital investment to support fundamental care transformation.

Governance

The RICTIC is a project of the state, although it is envisioned that the work of the Center would be conducted by organizations in the community under contract with the state. A leadership team that consists of representatives from state agencies and departments with a health focus will oversee RICTIC operations, and provide it with strategic guidance and direction. In addition to this leadership team, the RICTIC will include a Transformation and Innovation Council consisting of leaders in Rhode Island's health care innovation. The Council will serve a number of purposes, including advising the leadership team on policy direction, holding regular discussions on innovation and trends in Rhode Island and across the country, and reviewing the progress of Rhode Island's health care system toward the value-based care paradigm.

Workforce Development

While changes to the payment, clinical, and technology models in the health care environment are all essential to building a value-based care system, it is the workforce delivering care to patients that is essential to executing on the vision for the future. Rhode Island is building a workforce model for the future that is focused on realizing the triple aim and is both person-focused and supports providers moving to value-based care. In order make the next move into a value-based delivery system, Rhode Island has identified several important areas to focus on for its current and future workforce:

- **Develop uniform credentials and requirements for Community Health Workers:** CHTs will be crucial in the success of value-based care, and require the work of Community Health Workers. In order to ensure that they are able to fully execute their responsibilities and allow the other members of the Community Health Teams to work at the top of their licenses, these members will need uniform credentials, training and licensing requirements. Uniform credentials will also allow for the ability of multiple payers to support their use.

- **Conduct a workforce assessment:** A focused strategic assessment will give Rhode Island an analysis of the current workforce in supply in comparison to future needs in a value-based delivery system and reform efforts outlined in this plan. In addition, the assessment will provide an on-going evaluation tool for Rhode Island to use as the system moves further into value-based care, which will continually assess and rationalize the workforce. This will be an important tool that will have continued value for building the appropriate workforce and workforce pipeline in Rhode Island.

  The assessment will evaluate opportunities for further integration efforts around**:**

  - Pharmacy
  - Co-location of services
  - Behavioral health (currently under consideration by Health Care Planning and Accountability Advisory Council)
  - Long term care
  - Certified professionals
  - Licensed professionals
  - Opportunities for Telehealth

- **Develop curricula for in-service training for professionals as well as students:** Using the results of the focused assessment as well as other reports produced from assessments by OHIC and related entities, Rhode Island will work to remove 'siloed' curriculum models and coordinate education and training of the health care workforce for a value-based system. In coordination with the Department of Labor and Training, the Department of Health, graduate training programs and other participating agencies, the state will launch programs that:

  - Retrain the existing workforce and bridge existing gaps in today's workforce;
  - Address certification and licensure gaps and barriers for new and existing professionals;
  - Incentivize in-demand professionals to receive education and stay in Rhode Island through loan forgiveness programs or tuition payments; and
  - Coordinate and integrate the principles of the triple aim and a value-based delivery system across health care training programs for all member of the health care workforce with an eye toward future workforce needs.

Coordinated Health Planning

Rhode Island has broad statutory commitment to robust coordinated health planning. Broad health planning authority was developed and assigned to the Department of Health nearly 40 years ago. Numerous regulatory structures were then implemented to support the health planning process that remain today, including a robust licensure and certificate of need process. However, the state has been without an updated health plan for decades, leaving the regulatory authorities to rely on ad hoc,

circumstance-based decision making, rather than guidance from a health plan. An effort to re-ignite coordinated health planning was passed by the legislature in 2006 but budgetary constraints limited the activities until 2011. Investment in the planning effort began at a limited level, allowing up-to-date analyses of specific health care supply issues.

The transition to the value-based care paradigm requires in-depth and ongoing understanding of the Rhode Island health care system. It also demands an alignment of regulatory efforts to support plans to change the system. For this reason, Rhode Island needs an investment to support the creation of an up-to-date health plan for the state that supports the value-based care paradigm. The health plan will be developed through the Health Care Planning and Accountability Advisory Council, the legislatively created body charged with health planning activities.

HEALTH INFORMATION TECHNOLOGY AND MEASUREMENT

Rhode Island's transition to the value-based care paradigm cannot occur without technological innovation and data-fueled solutions. Despite significant investment in health information technology and analytics with strong early results, Rhode Island remains in a fragmented, un-coordinated system of data sharing, rather than a truly data-driven and measurement-focused networked health care system.

Moving away from fee-for-service health care requires powerful data and a coherent framework in which to share, analyze, and incorporate this information. For payers and providers to effectively transition away from fee- for service, both sides will need timely, accurate, and standard information about patients. Such data are more accurate and easier to compile for large numbers of patients, which makes partnerships and other provider arrangements a necessary part of value-based care in a state as small as Rhode Island.

These arrangements are best built on centralized information, which encourages coordinated care across sites and a thorough understanding of organizational finances and care patterns. For instance, physicians can provide better, cost-effective care if they have the patient's complete clinical, claims, and quality data for each patient at the point of care. A large provider organization refines its approach to costly or poor care by attacking specific weak points. It supports and tracks its high-utilizers by monitoring data over an entire network of providers. A care team – physician, nurse care manager, medical assistant – plan for interventions for the next day's patients by reviewing custom screening and health status reports.

Beyond the raw data, excellent team-based care requires shared tools, training and continuous analytic support from human experts. Practices need technical assistance on how to properly document a visit in their electronic health record so that quality measures accurately reflect the care they provide and so key clinical information stays with the patient. Most practices also need help interpreting and using this information to better manage their entire panel (high-utilizers, low risk patients, rising risk patients) and support their colleagues in total practice transformation.

The State, as both a payer and steward of public health, can better spot emerging disease trends, coordinate and evaluate interventions, and measure spending if it has population-level information. Finally, consumers are better patients when they can easily access their own health care records, find simple cost and quality information, and know how to weave this information into their health care decisions.

Technology and analytics are necessary to implement the value-based care paradigm and will require major investment, trust and coordination among all parts of the health care system. This effort will require both common underpinnings – such as harmonized measures and shared infrastructure – and flexibility. Each entity must be able to build a unique solution on a common base. Most importantly, it will require a statewide commitment to analytic, evidence-based thinking.

The four strategies below will build the right technology and analytics, not merely for their own sake, but to provide better care at a lower cost for a healthier population:

1. **Enable real-time and point of care patient data:** To move away from fee-for-service, providers need timely, relevant, and trusted data on individual patients at the point of care and at the organization level for strategic analysis.

2. **Offer technical assistance, training and shared analytic resources to providers:** Train practices on how to document, analyze, use and communicate their clinical, claims and quality measurement data. Coordinate shared analytic tools and support.

3. **Align quality, cost and utilization measures among payers and government:** Reduce the burden on providers to generate different, but often similar, measures for each payer and program. A community alignment process will help identify the state's health care priorities.

4. **Use data to drive state health policy:** Empower policy makers with clinical, spending and use data to track statewide cost, disease trends, and program effectiveness. Develop statewide data monitoring systems such as the All Payer Claims Database (APCD) and Currentcare.

HITM Tactics:

To achieve the vision and meet the goals outlined above, Rhode Island's State Health Innovation Plan proposes the following specific innovations.

1. **Enable real-time and point of care patient data:** To move away from fee-for-service, providers need timely, relevant and trusted data on individual patients at the point of care and at the organization level for strategic analysis.

Expand the presence and usability of Electronic Health Records (EHRs):

Meaningfully using a certified EHRs and being connected to Currentcare improves patient care and strengthens organization and state strategic planning, decision-making and public health monitoring.

- Through RICTIC's measurement work (see Strategy 2 below for more information), align federal, state and private sector incentives and reporting requirements for EHR use.
- Provide additional funding for the Regional Extension Center (REC) and the state's quality improvement organization (QIO) to help providers, including behavioral health and rural practices, achieve Meaningful Use for their EHRs. These assistance centers will also help practices best use their EHR for quality and clinical reporting purposes by teaching physicians how to properly capture and record data, generate reports, and build the EHR into their workflow.
- During practice consultation, the REC advises providers to use only those EHR vendors that comply with the interoperability requirements of Meaningful Use.
- Develop a strategy for federated identity management or single sign-on capability among clinical databases. This strategy would allow providers to use one set of credentials to access one or more of the following: their EHR, Currentcare, hospital system or private HIEs for which they have viewing privileges, and the state's prescription drug monitoring program (PMPD). This would begin by pilot testing the concept between Currentcare and the PMPD.
- Coordinate RICTIC, RIQI (which operates the REC), Healthcentric Advisors, to ensure EHRs connect to Currentcare and take advantage of its features.
- REC: Assist providers in meeting Meaningful Use with specific focus on the transitions of care requirements for Meaningful Use Stage 2.
- RICTIC: Help providers generate and incorporate clinical quality data from their EHRs into practice transformation plans.
- RIQI (via the REC), Payers: Create a multi-payer incentive for practices to enroll in Direct (a secure email exchange), sign up for admission/discharge/transfer (ADT) alerts, and enable the Viewer.
- State government: Agencies such as Medicaid and the Department of Health incorporate these features into their provider reporting programs to bolster the business case for Currentcare and EHRs.
- OHIC: Require value-based care contracts between insurers and providers stipulate the provider must have an EHR that meets Meaningful Use and fully connects to Currentcare, as described above.

Increase Enrollment and Scope of Currentcare

The state's health information exchange promotes timely analysis of aggregate and individual clinical data, the power of which grows with rising patient enrollment, practice participation, and submissions from providers.

- Build optional electronic Currentcare enrollment into Healthsource RI (HSRI), the state health benefits exchange, and private sector health insurance process. Train patient navigators and the HSRI call center operators to discuss the benefits of Currentcare and encourage enrollment.
- For providers engaged in value-based care arrangements, OHIC may require that 90% of their patients be offered enrollment in Currentcare within two years of contract signature.
- Work with RIQI and the insurer community to design and fund enrollment incentives similar to the existing BCBSRI/RIQI initiative.
- Build patient engagement tools into Currentcare. Such tools would include a portal for patients to access their full Currentcare health record, a stand-alone medication list and the ability to complete a "common intake form" before visiting a new physician.
- RIQI and RICTIC collaborate to engage more data-sharing partners, with a focus on specialists, mental health centers, imaging centers, home health agencies and payers for claims data. Note that the majority of hospitals, laboratories and pharmacies already provide data.
- RIQI and EHR vendors collaborate to build bi-directional exchange of Care Continuity Documents (CCDs). While Currentcare can receive, store and consume CCDs from private EHR, the reverse is not true. Most EHR vendors are not yet able to fully consume a CCD, which inhibits total patient care coordination.
- The state convenes payers (private and public) to integrate claims feeds into Currentcare for enrolled patients. Ensure that this submission minimizes duplication with the payer's APCD submission. For instance, ensure the file structures are as similar as possible and the filing dates are complementary.
- Expand the usefulness of DIRECT Messaging by encouraging payers to send reports to providers, and providers to send reports to HEALTH and other state agencies through Direct Messaging.
- Highlight the importance of statewide clinical health data by regularly publishing statistics and reports from Currentcare information. Focus on safe transitions, high-utilizers, and public health outcomes.

Provide timely (less than 3 months) claims feeds to providers engaged in value-based care until claims data can be incorporated into Currentcare or EHRs.

- Provide regular reports on high utilizers, prescription and hospital use trends and referral patterns using DIRECT Messaging as the communication method.
- Provide a monthly list of attributed patients to ensure providers and payers adjudicate their contract for an agreed-upon panel using DIRECT Messaging as the communication method.
- Structure claims feeds to meet contract adjudication and point of care needs, such as custom periodic reports and feeds that Currentcare or EHRs can read.

- Whenever possible, maintain the same file structure as the APCD or other claims reporting programs.

Establish a statewide authoritative Provider Directory that diverse data systems, agencies, and organizations can use. Such partners may include HealthSourceRI, the APCD, Currentcare, the medical licensure program, and Medicaid.

- The directory would support a variety of uses, including the ability to track relationships among providers and their affiliated organizations, accurately store data on practices and individual providers, and calculate a denominator for the number of provider practices in the state etc.
- Articulate the directory's governance, including the entities that oversee, operate, and maintain the database. Determine whether the directory should build off an existing system or be newly created.

2. **Offer technical assistance, training and shared analytic resources to providers:**

Train practices on how to document, analyze, use and communicate their clinical, claims and quality measurement data. Coordinate shared analytic tools and support.

- Establish the Rhode Island Care Transformation and Innovation Center (RICTIC) to coordinate analytic training and resource sharing.

One of the main functions of the RICTIC will be to develop analytic resource capacity – software, hardware, and people – and train provider groups on how to incorporate and communicate their data, and support providers as their own analytic capacity grows

- RICTIC will provide technical assistance and training to providers in analytics from HIT
- The priority users will include small, behavioral health and rural providers and those caring for complex patients such as high-utilizers, dually-eligibles, and those with developmental disabilities
- Analytic software and the accompanying technical assistance will analyze and learn from a practice's existing claims, clinical, quality, and financial data
- For all providers, offer initial and ongoing technical assistance for incorporating analysis into workflow and patient communication.
- Providers and consumers will test analytic tools to ensure they meet the needs of the practices, calculate accurate and relevant results and help practices meet core analytic competencies

3. **Align quality, cost and utilization measures among payers and government:**

Reduce the burden on providers from having to generate different, but often similar, measures for each payer and program. A community alignment process will also help identify the state's health care priorities.

- Harmonize metric definitions for cost, quality and utilization data.
- RICTIC will convene measurement alignment work to ensure that quality, spending and use metrics have common definitions.
- Develop a Data Intermediary structure to host and report on centralized quality data.
- The goal of the intermediary is to reduce the administrative burden for payers and providers involved in reporting similar, but slightly different, quality metrics to various oversight entities and health plans.
- The intermediary will store and aggregate data from providers, including from Currentcare, to calculate quality measures and report them to the respective oversight entities.
- These definitions will prioritize established national and state specifications.

4. **Use data to drive state health policy:**

Empower policy makers with clinical, spending and use data to track statewide cost, disease trends, and program effectiveness. Develop statewide data monitoring systems such as the All Payer Claims Database (APCD) and Currentcare and use these tools to support convening of alternative payment workgroups.

- Continue to invest in an APCD with de-identified claims data that supports population health management. Such a database may, for example:
  - Include claims data from many public and private sources.
  - Risk adjust the data using nationally-accepted risk adjustment method.
  - Produce regular, community-reviewed population-level reports on total and service-specific spending; disease trends by demographic categories, zip code, town and county; utilization reports by service types.
  - Include analytic capacity to calculate avoidable service use, such as potentially preventable readmissions and ambulatory-care-sensitive admissions.
  - Measure the frequency of volume sensitive conditions by provider.

- Measure the prevalence and frequency of services or diagnoses of interest, such as behavioral health care and substance abuse.

- Produce other reports and collect detailed claims data to support public health monitoring within state government.

Continue to invest in Currentcare's population health management capacity

- In addition to the enrollment, data submitter, provider engagement and technical assistance efforts described above, the state will coordinate with RIQI to deliver population-level reports on clinical and quality trends, disease surveillance and admission/discharge/transfer patterns.

Build the public reporting capacity of HealthSource RI (HSRI)

- Build data sharing capacity into the HSRI website to assist with health plan, provider networks and care selection. Such data may include information specific to health plans and providers, such as use, spending, and patient outcomes.

- Coordinate with the APCD and Currentcare to provide a consistent set of relevant data from these databases for public consumption

POPULATION HEALTH EFFORTS

Transitioning toward the value-based care paradigm in a way that supports the health of the community requires more than just realignment in the health care delivery system. Specific efforts to engage with the community in their health, along with affirmative support and efforts at prevention and health promotion, is a necessary component of the value-based care paradigm.

Social and community service resource directory. Providers will need access to up-to-date information on community services that can support the health goals of their patients for a team-based approach to providing quality care. Rhode Island will support the development of a web-based directory that will contain accurate, geo-located descriptions and contact information of the community-based services in Rhode Island. Services such as housing support, food/nutrition assistance, diabetes lifestyle management will be up-to-date and searchable, allowing members of the Integrated Care Teams to serve and connect their patients to valuable services

Through planning, encourage the state, cities and towns to understand social determinants of health. With increased emphasis on the importance of health prevention and patient engagement, and increased coordination within state government around health prevention issues, Rhode Island makes a commitment to ensure that the state, as well as its cities and towns, increases its awareness of the importance of population health as an outcome of sound planning efforts. This should increase the state's accountability for the health of its citizens when creating growth and development plans.

Communication. Rhode Island will leverage the integrated communications strategy developed by HealthSourceRI and the public health communication efforts led by the Department of Health. Building

on lessons learned and best practices in Rhode Island, the state will ensure that all health care reform messaging is well coordinated among entities. Through the development of Public Service Announcements (PSAs) and the use of social media, and other important channels, there will be fully coordinated (and appropriately translated) messaging to residents**.**

Create a sustainable, commonly available fund for prevention activities. The state of Rhode Island will standardize its prevention and public health efforts through a statewide funding mechanism that would provide services to all Rhode Islanders regardless of coverage type. Services could include vaccination efforts and the development of projects designed to improve the health of a community such as tobacco cessation, obesity prevention and disease-specific efforts. Rhode Island's base of community organizations will be further strengthened through these efforts.

Targeted, Sustainable Health Promotion Efforts. In an effort to meet Rhode Island's goal of improving the health of the population, the State will include efforts to reduce smoking, lower the level of obesity and the management of diabetes in the value-based care paradigm.

REDUCING SMOKING AMONG RHODE ISLANDERS

Rhode Island has a long and successful history at reducing the rate of smoking in its population. The state's efforts are coordinated through the Tobacco Control Program at the Department of Health. The Tobacco Control Program (TCP) works to eliminate tobacco-related disease by creating environments that make it harder for people to start using and continue using tobacco. Preventing tobacco use and exposure to second and third-hand smoke is critical to the health of our state and the TCP relies heavily on informative statewide educational initiatives, innovative traditional and social media campaigns, state and local data collection and dissemination, and funding of cessation services to accomplish this goal.

Accomplishments and Milestones

- **Rhode Islanders are kicking the habit.**
  Rhode Island's adult smoking rate has seen a dramatic reduction from 23% in 2001 to 16% in 2010 (RI BRFSS 2000, 2010).

- **Rhode Island youth refuse to be "replacements".**
  For every customer that dies, tobacco companies look for a replacement. However, tobacco companies are note finding young replacements in Rhode Island. The youth cigarette smoking rate has plummeted from 35% in 2001 to 11% in 2011. Rhode Island is proud to have the third lowest youth smoking rate in the US (RI HS YRBS 2001, 2011).

- **Rhode Islanders can breathe easier.**
  Smoke-free Workplace Law: On June 29, 2004, Rhode Island became the seventh state in the nation to pass into law a bill that prohibits smoking in public places and workplaces in Rhode Island.

- **Rhode Islanders can get the help they need.**
  If you or someone you know are ready to quit smoking, there are a number of ways to get help.

- Health insurers now cover cessation services. In August of 2009, The Office of the Health Insurance Commissioner's Regulation 14 has required health insurers to offer broader coverage of smoking cessation services.

- The TCP has created www.QUITNOWRI.com to provide information on cessation resources available to all Rhode Islanders. The site also features video from its recent media campaign, motivational ring tones and encouraging personal stories.

- Cessation services can also be accessed through a toll-free number.

- **Smoking is an expensive habit.**
  Rhode Island has consistently increased the cigarette excise tax rate, making smoking difficult to afford. RI currently has the second highest tax rate in the US at $3.50 per pack. High prices for cigarettes increase quit attempts, especially among young and lower income smokers.

Rhode Island will continue its efforts to reduce smoking, building upon the requirement that cessation services are covered by insurers. Including evidence-based smoking cessation measures in the required outcome measures, on which provider organization will be evaluated, will support the efforts that are already underway.

REDUCING OBESITY

While Rhode Island's obesity rate is slightly below the national median, the percentage of Rhode Islanders at greater risk for chronic diseases due to being overweight or obese is a major concern for Rhode Island's health. In RI, 74% of adults do not consume five or more servings of fruits and vegetables daily. Fifty-seven percent(57%) of adults consume fast foods one or more times a week and 28% consume at least one sugar-sweetened beverage a day. In addition, 50% of adults do not meet physical activity recommendations and 60% watch two or more hours of TV a day. That means a combination of nutritional factors along with low levels of activity have created a perfect storm for the increase of overweight and obesity in our state (Rhode Island Department of Health, 2010).

Rhode Island intends to conduct the following activities to reduce obesity:

OBJECTIVE 1: By December 30, 2015, 6 core city neighborhoods will make at least two documented improvements in community walk ability, safety, access to recreation and access to healthy foods.

- Strategy 1a: Build community capacity to make policy and environmental changes.
  - Cultivate partnerships with non-traditional partners, such as smart growth advocates, neighborhood revitalization groups, and environmental groups.
  - Provide seed funding to core cities to coordinate communitywide efforts.
  - Assess the food and activity environment, identify strengths and gaps.
  - Develop community action plans to maximize strengths and address gaps by leveraging existing resources for policy and environmental change.
  - Mobilize community members and key stakeholders to advocate for community change.

- Identify and recommend model policies for food access, walk ability, safety, and recreation.
- Link communities with programs like Fresh To You (fresh produce delivered to community sites and sold at discount prices), Farm Fresh RI and Farmers' Markets to increase access to healthy foods.

- Strategy 1b: Strengthen city and town comprehensive plans to ensure healthy eating and active living are considered.
    - Contribute to the update of RI's Statewide Planning Handbook on the Local Comprehensive Plan to include access to healthy foods, walk ability, access to recreation, and safety.
    - Develop healthy eating and active living criteria that will be used to evaluate comprehensive plans and provide structured feedback to community planners.
    - Provide HEALTH recommendations and related model policies during the review process.

OBJECTIVE 2: By December 30, 2010, all full-service and fast food restaurants with 15 or more sites nationally will provide calorie information at the point of purchase.

- ***Completed through Patient Protection and Affordable Care Act***

OBJECTIVE 3: By December 30, 2015, 30 restaurants will be publicly recognized for providing healthy food and beverage options.

- Strategy 3a: Implement a restaurant training, technical assistance, and recognition program.
    - Conduct formative research with restaurant stakeholders.
    - Use research results to develop a training program on developing and preparing healthy meal options.
    - Develop a co-op program with Johnson and Wales University to place students in restaurants to provide additional training and technical assistance.
    - Recognize and promote restaurants that complete the training and co-op program and implement changes to their menus.
    - Provide ongoing training and technical assistance to restaurant

OBJECTIVE 4: By December 30, 2015, 25% of licensed childcare facilities will provide menus consistent with the Dietary Guidelines for Americans.

- Strategy 4a: Strengthen the knowledge and skills of food service providers, caterers, and childcare facility staff on purchasing and preparing healthier meals and snacks.

- Provide training and technical assistance to food service providers, caterers, and facility staff.

- Strategy 4b: Require that all childcare facilities serve meals and snacks that comply with Dietary Guidelines for Americans.
  - Build stakeholder support for strengthening nutrition criteria.
  - Develop nutrition guidelines for childcare centers that promote healthier eating.
  - Work to increase reimbursement for healthier foods.
  - Mobilize stakeholders to advocate for changes to childcare nutrition guidelines.
  - Provide ongoing technical assistance.

OBJECTIVE 5: Between January 1, 2009 and December 30, 2015, increase participation in selected best- and promising-practice community nutrition and physical activity programs.

- Strategy 5a: Expand and promote the We Can! Community Program.
  - Train community agencies and supply We Can! materials.
  - Provide ongoing technical assistance.

- Strategy 5b: Expand and promote the Department of Environmental Management's RI Great Outdoors Pursuit.
  - Expand the reach of the campaign to target low income, urban families.
  - Develop tools to evaluate impact in low income areas.

- Strategy 5c: Implement and promote the Operation Frontline nutrition education program.
  - Identify lead agency and key partners to provide chefs, dietitians, and program sites.

- Strategy 5d: Identify and promote evidence-based local healthy eating and active living programming.
  - Do an audit of local programs and identify those with evidence of effectiveness.

- Strategy 5e: Develop and maintain a web portal to provide residents and professionals with easily accessible program and resource information.
  - Identify sentinel programs to track enrollment for evaluation.
  - Develop comprehensive website, housed at www.health.ri.gov.
  - Compile program information through partner surveys.
  - Promote the website to partners, health care providers, and the public.

OBJECTIVE 6: By December 30, 2015, all RI Health Centers will integrate obesity prevention into routine primary care.

- Strategy 6a: Ensure coverage of preventive services, such as nutrition counseling, behavioral counseling, and patient reimbursement of weight management program costs by RI's four major health insurers.
    - Identify best practices for obesity prevention and management to integrate into an enhanced pediatric primary care model and develop a model appropriate for RI.
    - Work with insurers to provide coverage.
    - Pilot the model and evaluate effectiveness.

- Strategy 6b: Provide pediatric providers with tools and training to better address obesity prevention.
    - Research barriers and needs of providers.
    - Develop tools and training to assist providers.
    - Hold training series for pediatric providers.
    - Evaluate tools and training in multiple sites.
    - Expand the program statewide.
    - Build tools into KIDSNET to assist providers.

- Strategy 6c: Provide adult providers with tools and training to better address obesity prevention.
    - Implement a media campaign to cue patients to talk to their providers about reaching or maintaining a healthy weight.
    - Provide providers with tools and training to effectively and efficiently assess BMI, counsel patients, and make appropriate referrals.

OBJECTIVES 7 AND 8 OMITTED

OBJECTIVE 9: By December 30, 2015, all 6 core cities will have Safe Routes to Schools programs.

- Strategy 9a: Promote Safe Routes to School (SRTS) programs with core city districts and provide technical assistance.
    - Provide tools and training to interested core cities on walk ability assessments and safety to develop applications for SRTS funding.
    - Fund schools' SRTS teams in core cities.
    - Provide training and technical assistance.

OBJECTIVE 10: By December 30, 2015, 60 small-to medium-sized RI worksites (under 400 employees) will implement documented policy and environmental changes that support physical activity and healthy eating.

- Strategy 10a: Implement Shape Up RI worksite competition in work sites that employ lower income workers.
    - Outreach to smaller worksites and those serving lower income workers.

- Develop tools to assist worksites where employees may not have computer access or speak/read English.
- Provide ongoing technical assistance to worksites.

- Strategy 10b: Implement the Fresh to You worksite produce market in all RI core cities.
  - Outreach to smaller worksites and those serving lower income workers.
  - Develop tools to assist worksites where employees may not have computer access or speak/read English.
  - Accept Supplemental Nutrition Assistance Program Electronic Benefits Transfer (EBT) and/or WIC checks at worksite markets.
  - Provide ongoing technical assistance to worksites.

- Strategy 10c: Provide employers with tools and resources to make policy and environmental changes in the workplace.
  - Develop a website structure to serve as a clearinghouse for worksite nutrition and physical activity policy and program resources.
  - Compile tools (assessments, ROI calculators, toolkits, model policies, sample surveys, research) for the website.
  - Promote website among small- to medium-sized employers.

OBJECTIVE 11: By December 30, 2015, 40 worksites will implement policy and environmental supports for breastfeeding mothers.

- Strategy 11a: Promote DHHS's The Business Case for Breastfeeding employer lactation support toolkit among community partners and businesses.
  - Identify community partners and businesses for collaboration.
  - Distribute toolkit to community partners and businesses.
  - Provide ongoing technical support and guidance.

- Strategy 11b: Recognize worksites that effectively accommodate breastfeeding mothers through the annual Breastfeeding-Friendly Workplace Awards.
  - Promote Breastfeeding-Friendly Workplace Award to employers.
  - Sustain annual Breastfeeding-Friendly Workplace Award recognition.
  - Provide ongoing breastfeeding education and access to relevant community resources to employers and their employees.

OBJECTIVE 12: By December 31, 2015, have a state infrastructure for obesity prevention that will ensure adequate staffing, funding, and support to sustain the initiatives outlined in this Action Plan.

- Strategy 12a: Develop an annual Eat Smart Move More Policy Agenda and corresponding advocacy campaign.
    - Form a Policy Group of high-level leadership and community partners to develop RI's Eat Smart Move More Policy Agenda and campaign.

- Strategy 12b: Develop teams of trained community advocates in each core city.
    - Fund up to three core city teams per year to increase their advocacy capacity.
    - Work with School District Health and Wellness Subcommittees to expand their advocacy efforts.

- Strategy 12c: Develop a convergence of funders across sectors and fields to maximize investments in the policy and environmental changes in the Action Plan.
    - Convene funders and share information about the importance of addressing obesity prevention from a policy and environment perspective.
    - Provide technical assistance and support to funders.

DIABETES CARE MANAGEMENT

Rhode Island has identified the burden of diabetes on the health of its population, as discussed in Section XX. The management of diabetes has been a top priority in Rhode Island for more than three decades. The Diabetes Prevention and Control Program (DPCP) coordinates the Rhode Island Statewide Diabetes Health System (RI-SDHS), which is comprised of over 700 agencies and individuals. The goal of the DPCP is to prevent and control diabetes and diabetes-related complications. The DPCP adopts, implements, evaluates, and institutionalizes programs to improve the quality of diabetes clinical care. It expands the workforce available to address the burden of diabetes in RI by supporting multicultural diabetes self-management programs, education and pre-diabetes care. These programmatic elements work together synergistically and on multiple levels (i.e., individual, health system, environmental, community, state) to constitute a comprehensive systems approach to diabetes prevention and control. Specifically, the DPCP works to:

- Facilitate collaboration among public and private sector partners;
- Define the burden of diabetes and assess existing population based strategies for primary and secondary prevention of diabetes within the state;
- Develop and update a comprehensive state plan for diabetes prevention with emphasis on physical and social environmental change, and disparities elimination;
- Identify culturally appropriate approaches to promote diabetes prevention among racial, ethnic and other priority populations

Goals and Accomplishments

- The DPCP seeks to increase the number of RI Chronic Care Collaborative health center sites that have met 3 out of 4 clinical quality measures targets or improved those measures by least 5%. Clinical outcome measures include a Hemoglobin A1c less than 8mg/dl, an LDL of less than 100 mg/dl, a blood pressure of less than 130/80 and an increase in the number of patient with diabetes who have set a self-management goal. As of 2013, five health center sites have improved 3 out of these 4 clinical outcome measures by 5%.

- The Certified Diabetes Outpatient Educator workforce has increased to 303 Registered Dietitians, Nurses and Pharmacists. The DPCP and the Living Well RI programs have provided leader trainings to increase the workforce available to facilitate Chronic Disease and Diabetes Self-Management programs Currently there are 32 Master Trainers and 71 Leaders. 541 participants with diabetes and other chronic diseases have completed a Living Well program.

- Rhode Island is ahead of the US national average for four out of six Healthy People 2020 objectives for which 2010 RI data were available including age-adjusted percent of adults with diagnosed diabetes who have had an annual dental exam, annual foot exam, annual dilated eye exam, and at least two hemoglobin A1c tests in the past 12 months. RI was behind the national average for percent of adults with diagnosed diabetes who have performed self-blood glucose monitoring at least once daily, and have ever received formal diabetes education.

- At 65.6%, there was a 14% increase in the percent of adults with diabetes in the RI Chronic Care Collaborative registry who have documented self-management goals.

Rhode Island's Value-Based Care Paradigm includes efforts to improve both prevention and care management of diabetes. In fact, Rhode Island's patent-centered medical home project, CSI-RI, includes three contractual performance measures for the management of diabetes. Diabetes measures, specifically the health outcomes of persons with diabetes will be included in the measure set for the value-based care paradigm. Additionally, the value-based care delivery system will utilize and build upon the efforts of the DPCP, especially the Certified Diabetes Outpatient Educator program, in conjunction with Community Health Teams.

H. IMPLEMENTATION OF RHODE ISLAND'S HEALTH CARE INNOVATIONS

The implementation of each of these innovations can be affected using a number of levers controlled by the state. Success also relies on continuing collaborative efforts with private sector partners – insurers, providers, consumers – with state support through regulatory and statutory reform as it is needed. Consistent with the development of this plan, any implementation, whether mandated or collaborative, should be made in coordination with a broad stakeholder group to ensure an effective program that meets the goals of this plan.

Payment Transformation

The necessary changes to payment models to support the transition to value-based care can be achieved using policy and regulatory levers currently at Rhode Island's disposal. In the last year, Rhode Island passed legislation directing the Office of the Health Insurance Commissioner (OHIC) to "monitor the transition from fee for service and toward global and other alternative payment methodologies for the payment for health care services. Alternative payment methodologies should be assessed for their likelihood to promote access to affordable health insurance, health outcomes and performance. " OHIC has already used this authority to require a growing investment in primary care by all commercial insurers. That requirement has helped build much of the foundation for the reforms underway and proposed in this plan. Given OHIC's statutory responsibility, and the previous authority conferred to OHIC to consider affordability as a factor in reviewing proposed health insurance rates, the move to payment models that support the value-based care paradigm can be required by OHIC. This would impact the fully-insured market in Rhode Island, consisting of the individual market, the small-group market and those large groups that are fully-insured. Additionally, many employers in Rhode Island who are self-insured use Rhode Island's commercial insurers to administer their plans. Therefore, OHIC's regulatory efforts would likely have an impact on the self-insured market.

In addition to the regulatory efforts on payment transformation, Rhode Island has a number of contractual arrangements that could be leveraged to support the transition to the value-based-care paradigm. The state employee health plan, which covers over 50,000 Rhode Islanders between employees, dependents and retirees, can require its plan administrator to engage in payment models that support the value-based care paradigm. Additionally, Medicaid contracts with payers to provide managed care services to most of its members. These contracts can include the dual requirement to support the value-based care paradigm through its Medicaid managed care program, as well as setting a requirement for payment transition in its non-Medicaid business as a requirement to participate in Medicaid.

Changes to the Medicaid payment structure can be conducted as part of Rhode Island's 1115 waiver authority in consultation with CMCS.

TIMELINE

The Office of Health Insurance Commission provides instructions for health insurers to file rates in the first quarter of the year. Due to the complexity of creating contracts that would fit the value-based care

paradigm, requirements on insurers should not be implemented until 2015. However, during the coming year, OHIC will work with insurers to develop requirements that are constructive and support the move to the value-based care paradigm. Due to contract renewal timing, the alignment of contracts can occur over the next three years.

The state Medicaid program is currently negotiating a waiver that has many reforms discussed here included in its initial proposal. They are also implementing an integrated care initiative that aligns payment and delivery in the long term care system with acute and primary care. Both of these initiatives are being designed and implemented during 2014 and 2015.

Delivery System Enhancements

Each of the delivery system enhancements has a different framework for implementation and each is already in its own phase of pilot or implementation. However, the enhancements build upon each other and must be pursued together.

Patient Centered Medical Homes

In 2011, Rhode Island codified its support for patient centered medical homes in statute. A law passed in 2013 requiring participation of the state employee health plan in the state's patient-centered medical home project bolstered that support. An amendment to the state's patient-centered medical home statute committing to state-wide scaling of patient-centered medical homes to provide access to any Rhode Islander will codify that commitment. The actual work of scaling up PCMHs in Rhode Island requires enhancements to the delivery system to support smaller practices that may have more challenges meeting the objectives of a PCMH. These enhancements are included in the effort to introduce Community Health Teams and provide them as a shared resource to smaller practices. The CSI program has also undertaken a major expansion during the past year that will expand capacity to 260,000 Rhode Islanders. However, there are some geographic limitations to CSI that would need to be addressed to meet the goals of state-wide access to a PCMH.

TIMELINE
The state will introduce legislation in 2014 to affirm the commitment to expand access to a PCMH to all Rhode Islanders by 2020.

Community Health Teams

CSI-RI is currently piloting Community Health Teams in two Rhode Island communities. A scaling of Community Health Teams as envisioned in this plan would require payment support as envisioned under the payment transformation section. It would also require investment. There is no policy or regulatory lever that can cause Community Health Teams to be created or used, rather they must be created to be used. Ongoing funding of Community Health Teams is sustainable and can be made through payments to primary care practices, as is done in the current pilot program.

TIMELINE

The state would create community health teams contingent upon a SIM model test award and develop the tactics for their implementation and required startup investment upon funding.

Behavioral Health System Reform

The first step in creating effective integration of the behavioral health system with the medical care system is to convene an action-oriented workgroup consisting of providers, payers, policy-makers and consumer advocates to tackle the issue. In 2013, the state legislature created a joint commission to study the integration of primary care and behavioral health in the state. The commission has been meeting regularly and their recommendations are expected in the spring of 2014.

The strategies of co-location are also underway already. The state's Health Home project, along with other private co-location efforts have shown promising results – provided the co-location leads to effective coordination of care.. Further support of this model is warranted given a commitment to integration. Due to the high level of state support for behavioral health services, co-location of services can be driven by state payment policies.

TIMELINE
The state will continue to support the model of co-location and evaluate proposals to further integration in 2014.

System Transition

Rhode Island Care Transformation and Innovation Center (RICTIC)

As discussed earlier, a number of efforts at care transformation are already underway in Rhode Island. The creation of the RICTIC would only need two elements for start-up: the payment transformation that creates the needs for practice transformation, and funding to support the contracts for the activities of the RICTIC.

A key factor in the value of the RICTIC to the provider community is the regulatory structures surrounding provider organization under the value-based care paradigm. The state is currently conducting a detailed analysis of the state's statutory and regulatory construct as it impacts the value-based care paradigm. Legislation addressing value-based care and financial responsibility by provider organizations is expected in 2014. The RICTIC would take a prime role in assisting providers to adapt to any changes in the regulatory or statutory structure.

TIMELINE

During the first half of 2014, a RICTIC implementation workgroup will be convened to create the framework for the initial 12-month strategy for the RICTIC. Additionally, the creation of the procurement documents for the RICTIC will be developed. In the second half of 2014, the state will convene the initial meeting of the Accountable Care Collaborative. Further efforts of the RICTIC would require a dedicated source of funding.

Workforce Development

COMMUNITY HEALTH WORKERS

The development of credentialing for Community Health Workers must be conducted in coordination with the implantation of Community Health Teams, and building on the 2011 legislation creating an explicit role for Community Health Workers in Rhode Island to address health disparities in the state. As Community Health Teams are created, the role of Community Health Workers must be clearly defined in the context of the CHTs. As this role is defined, a process for ensuring that Community Health Workers are trained to perform that role must be developed. There is currently a Community Health Worker training program managed by a community-based organization. This program can be easily leveraged to address the needs of CHTs.

WORKFORCE ASSESSMENTS

The state Health Care Planning and Accountability Advisory Council has already undertaken an examination of primary care capacity in the state. Based on a legislation passed in 2013, the council is starting an in-depth study of the behavioral health system in the state, including a profile of the workforce. Further workforce assessments are dependent upon funding for work and this funding is included in the work of Coordinated Health Planning discussed later.

EDUCATIONAL ALIGNMENT

In coordination with the Rhode Island Care Transformation and Innovation Center, the curriculum for value-based care in-services will be developed in 2014 for educational opportunities in 2015. Additionally, a number of educational facilities that train health care workforce have expressed an interest in including elements of collaborative care model in their curricula. The state's only medical school, the Alpert Medical School at Brown University, has also announced a new program focusing on primary care and has expressed interest in incorporating aspects of value-based care into its training.

TIMELINE

As the requirements and structure of CHTs are developed through 2014, the role of Community Health Workers can be defined. By the start of 2015, any needed changes to the state's Community Health Worker law can be identified and forwarded to the legislature for the 2015 session. The behavioral health system assessment will be underway by the second quarter of 2014. Depending on funding further assessments could be started within six months. Educational curricula for RICTIC supported in-services will be created during 2014 with support from the Accountable Care Collaborative.

Health Information Technology and Measurement

New and expanded utilization of technological resources is a necessary component of the value-based care paradigm. However, this new technology requires significant investment in infrastructure, staff and training. In fact, a Rhode Island provider organization that is well under way in the transition to the

value-based care paradigm has suggested that the IT transition is more difficult than adapting to new payment structures. Until EHR infrastructure catches up to the needs presented by provider organizations in the value-based care paradigm, there will need to be thoughtful, adaptive support for providers to draw more from their technology.

ENABLE REAL-TIME AND POINT OF CARE PATIENT DATA

Complete, real-time data is the ultimate goal of an effective, system-wide EHR system. State support for creating the structures to enable the health care system will accelerate the development of real-time access. A key element to this infrastructure is the All Payer Claim Database (APCD). The APCD is under active development with data feeds beginning in 2014. Additionally, the state's Health Information Exchange, Currentcare, is a key element to real-time data. Both of these systems are created through statute and each statute has strict privacy protections that may impact the ability to leverage the systems for the value-based care paradigm. Ongoing examination of these programs is necessary to ensure their utilization in the value-based care paradigm.

OFFER TECHNICAL ASSISTANCE, TRAINING AND SHARED ANALYTIC RESOURCES TO PROVIDERS

The RICTIC, as part of its implementation plan will consider the resources available now to practices through a number of Rhode Island organizations. Efforts of Healthcentric Advisors and the REC program of RIQI have been underway to assist providers as they incorporate technology into their practice. The RICTIC would work closely with those organizations to identify providers that are ready to progress to the next level of using HIT to report quality measures and develop analytic capacity to support population health efforts.

ALIGN QUALITY, COST AND UTILIZATION MEASURES AMONG PAYERS AND GOVERNMENT

Rhode Island is currently preparing a request for information to determine available strategies to harmonize measures for the purposes of payment transformation. Implementation of these tactics will depend in large part on information learned through the RFI process. Requiring measures to be harmonized across payers is critical to the success of the value-based paradigm. OHIC authority over commercial insurers provides necessary leverage to require payers to use the same measures under the value-based paradigm. However, the state's experience with the CSI-RI program suggests that if providers develop a set of measures that they are focused on attaining and improving upon, the payers in our state will accept them without regulatory obligation. Key to statewide adoption of the harmonized measure will be policy changes in the Medicaid payment system that allows flexibility to adopt community-derived measures.

TIMELINE

The most time-sensitive piece of the Health Information Technology and Measurement strategy is the harmonization of quality measures. This work has been underway through CSI-RI for measures used by the state's PCMH project and new measures must be developed that meet the state's population health goals. This expansion work will begin in the second half of 2014 to be included in payment structures in 2015. As quality measures are integrated into payment systems, providers will need assistance and

support to leverage their IT systems in 2014 and 2015. This will be an early area of focus for the RICTIC as it begins its work.

I. DRIVER DIAGRAM / LOGIC MODELS

In this section is a series of tables that lays out specific objectives that this plan attempts to reach. Also included in these tables are the identification of potential outcome measures, the sources of potential data and an indication of how each intervention incorporates one or more of the key pillars of Rhode Island's reform efforts.

AIM 1: REDUCE FEE-FOR-SERVICE PAYMENT MODELS

Innovation Activity/ Intervention	How	Outcome	How to measure outcome	Pillars
Form coalition to encourage creation of ACO-like organizations in the commercial and public market	With the state as convener, bring players to the table to form work group –, to create contracting standards, identify regulatory and policy changes needed, new relationships between providers and payers	Lower overall health costs to state and payers; less duplication of services; lower utilization rates.	Cost of care project by OHIC; 33+ NCQA quality measures; PQRS	Multi-Payer Payment Transformation Accountability
Encourage the development of value-based options for state employees, retirees and municipalities to ACO-like structures	State as payer can increase # of RI's in value based care and payment arrangements by using its purchasing power to change the payment system.	State's health care costs decrease through lower utilization and improved quality of care	Claim data; quality metrics based on NCQA 33 measures; PQRS	Multi-Payer Payment Transformation Accountability
For Medicaid recipients and Dual Eligibles, develop state contracts for a primary-care led ACO that will manage and deliver full services on a shared-savings basis.	State as payer can increase # of RI's in value based care and payment arrangements by using its purchasing power to change the payment system	State's health care costs decrease through lower utilization and improved quality of care	Claim data; quality metrics based on NCQA 33 measures; PQRS	Multi-Payer Payment Transformation Accountability
Support steps : from P4P, Bundled services, Shared Savings, to global capitation	Lower cost and utilization, improved primary care	33 quality measures(NCQA); PQRS		Multi-Payer Payment Transformation

AIM 2: CREATE A MORE COORDINATED SYSTEM OF CARE

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
ACO-like organization's will create integrated delivery systems	Possible OHIC regulatory changes and ACO coalition; benefit design that encourages (doesn't limit) staying within network, within RI.	Better integration of clinical services, reduced duplication of services, improved communication and teamwork between providers	Increased EMR adoption; APCD, invest in business intelligence tools such as care and disease registries at state and provider levels , provider directory, increased adoption and use of CurrentCare	Patient / Consumer Centric
Incent data reporting, transparency, and consistency across providers, e.g., Provider Directory, CurrentCare, APCD. Maintain a common set of input and reporting standards for all data aggregation tools, including a harmonized set of measures for all payers and shared quality reporting infrastructure to serve as data intermediary for quality reporting and to provide feedback to providers and public	With state as convener, provide tools for provider organizations to communicate across interoperable systems; provide financial incentives for small and independent primary care practices to adopt and use technology that reduces fragmentation; develop and implement shared quality reporting infrastructure (intermediary) promote further expansion of Currentcare	Better integration of clinical services, reduced duplication of services, improved communication and teamwork between providers	Assess increased EMR adoption; APCD, invest in and monitor business intelligence tools such as care and disease registries at state and provider levels , provider directory, increased adoption and use of CurrentCare' monitoring of aggregated quality measures, monitoring of changes in practice based on quality measurement feedback to providers	Accountability Transparency
Grow the presence of PCMHs in Rhode Island	Incent independent primary care doctors to transition into PCMHs and to contract with entities developing toward an accountable and shared risk structure.	Reduced hospitalizations including ED use, reduced duplication of services, improved health care experience/health for patients, better management of chronic diseases, reduction of high utilizers.	Track number of practices participating and patients being treated within model.	Multi-Payer Payment Transformation Patient / Consumer Centric

AIM 3: CREATE SAFE TRANSITIONS OF CARE TO IMPROVE HEALTH OUTCOMES

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Expansion of Community Health Teams will provide resources to support, coordinate and aid patient transitions from hospital to/or LTC then home	Regulatory changes will be needed to ensure that payers contribute to the finance of this expansion over time. Some support will be provided from Medicaid under 1115 waiver, facilitate data sharing during transition of care through EHR adoption and meaningful use (MU) state 2 (has transition of care requirements to share data), alignment of MU and state Continuity of Care form, Currentcare adoption	Reduction in admissions, reduction in duplicate services, better patient experience and outcomes, reduction of high utilizers, fewer transitions overall	APCD, state continuity of care form, Currentcare, patient satisfaction surveys	Multi-Payer Patient / Consumer Centric Community Assets

AIM 4: CREATE STRUCUTRES THAT REDUCE OVER-UTILIZATION OF UNECESSARY SERVICES

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Community Health Teams: based outside of provider practices: includes lower care-giver to patient ratio, telemedicine, coordination with community resources; the use of Extensivists – especially for the Medicaid/Medicare populations specifically with behavioral health and pregnancy conditions; include Recovery Coaches in CHT's	Form care-giver teams of nurses, allied and community health teams within an ACO-like structure to address the needs of the top utilizers. Place case managers in ED's.	Reduced ED visits Reduced pre-term births Reduced readmission Higher recovery rates	Claim data; quality metrics (NCQA); hospital admission/readmission rates	Multi-Payer Patient / Consumer Centric Community Assets
Intermediate intensity services for highest cost Medicaid/Medicare population; provide an alternative to the Emergency Department where their needs can be met in a more appropriate setting;	Develop ambulatory ICU, sobering centers, home-based primary care – more work is needed to define these interventions.	Reduced ED visits, reduced hospitalizations		Payment Transformation Patient / Consumer Centric Accountability

AIM 5: INCREASE PREVENTION ACTIVITIES AND SCREENING FOR RISING RISK POPULATION

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Promote healthy life styles Manage preventive care through the PCMH model Use technology, health risk assessments to track and report on progress at the provider or group level Use technology (e-health tools, patient portals), patient generated data to support patient engagement	Expand PCMH availability through positive incentives; marketing campaign in increase education and awareness for well and preventive care; develop patient portals and e-health tools for Currentcare Consider developing specialized PCMH's for behavioral health and/or substance abuse patients	Reduced number of patients entering into the high risk category in order to sustain savings realized by high risk interventions.	Increased collection and reporting on health status of RI; Community Needs assessment from HARI; tools connected to APCD	Patient / Consumer Centric Transparency Community Assets

AIM 6: INCORPORATE ALL RHODE ISLANDERS IN LIFELONG SYSTEM OF CARE

Innovation/ Activity/ intervention	**How?**	**Outcome**	**How to measure outcome**	Pillars
Public education and health promotion campaigns, e.g., PSAs, that emphasize the importance of good health; focus on behavioral and maternity care; Increased preventive screenings, health risk assessments	Increase PCMH access, marketing campaign for education on the importance of well-care	Healthier more engaged consumers especially among young adults; increased patient engagement and activation; increased PCP visits	Community Needs Assessment, tools reporting on social determinants of health in coordination with the APCD	Patient / Consumer Centric Transparency Community Assets

AIM 7: INTEGRATE BEHAVIORAL HEALTH SYSTEM INTO OVERALL HEALTH SYSTEM

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Co-location of behavioral health and primary care providers: Ensure adequate infrastructure for the most acute BH conditions; integrate lower level conditions with primary care.	This will be incented by all payers – including Medicaid paying for some services through the support of CHT specialists; sharing of behavioral health data through Currentcare	Improved access to BH for low acuity patients and improved access to primary care for SPMI	Lower costs; improved mental health outcome data; annual survey	Multi-Payer Payment Transformation Patient / Consumer Centric
Programs to support recovery programs for substance abuse treatment participants	Peer-led, voluntary support services	Improved outcomes		Patient/Consumer Centric

AIM 8: PROVIDE GREATER ENGAGEMENT AND UNDERSTANDING THROUGH TRANSPARACY

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Improve ability to collect, analyze, find and distribute/report health care information through the introduction or improvement of HIT tools, such as statewide shared quality reporting infrastructure to benchmark and feed results back to providers and to support public reporting program	Identify an entity to take responsibility for creating/managing these tools and their governance; promote sharing of cost and quality information to the public	Provider Directory, APCD, Currentcare, harmonized measures, quality reporting data intermediary, increased HIE and EHR usage, Social Service Agency/Org. Directory, and identification of further options to promote interoperability	Claims data, quality measures, HealthSourceRI	

AIM 9: ENGAGE RHODE ISLANDERS IN THEIR HEALTH

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Provide Navigators, Require Personal Health Risk Assessments, Design Marketing and Communication campaign, patient engagement tools and currentcare patient portal, health promotion activities	Strengthen HealthsourceRI to take on these responsibilities, build out Currentcare portal, develop marketing communication campaign	Improved awareness and understanding of how health system works, and how to reduce one's own risk factors	Provider surveys, Hospital Association of Rhode Island's Community Health Survey	Patient / Consumer Centric Accountability Transparency Community Assets

AIM 10: INTEGRATE COMMUNITY-BASED ORGANIZATIONS INTO HEALTH CARE SYSTEM

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Provide technical assistance services, collaboration group, empower CBO's to more directly address social determinants of health	Identify an entity to take responsibility for creating/managing these efforts	Improved integration of these organizations in the health care system; they will provide lifestyle supports and resources for providers	Tracking and monitoring number of organizations entering into partnerships with providers;	Community Assets

AIM 11: RENEW FOCUS ON SOCIAL DETERMINANTS OF HEALTH

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Establish inter-agency education and information programs that articulate impact of social determinants of health on different agencies. Information will be routed in improved data collection and research on the social determinants of health of Rhode Islanders, and will include robust reporting on the economic and social implications of the relevant SDHs to each department	Incorporate health care awareness into city/state planning	Dissemination of information will incorporate the full definition of health into agency priorities and budget and agenda setting will start to reflect health of Rhode Islanders.	Tracking and monitoring the inclusion of health outcome oriented programs, policies, etc. over time.	Transparency Community Assets
Creation of a Health Care Innovation Trust Fund	Provide continual funding for programs designed to address this need	The state and community will discover the best ways to influence these causes of poor health and health disparities; will increase awareness of and importance of the social determinants of health	Documenting the process of development and determining whether the goals of the intervention are being met.	Payment Transformation Community Assets

AIM 12: REDUCE HEALTH DISPARITIES

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Access through ACO-like organizations, common care protocols/guidelines and incentives will improve access and outcomes.	Move Medicaid population into ACOs that take on multi-payer clients; move payment to value-based with the potential for bonus or shared savings payments.	Decreased differences in key health outcome measures between groups.	Claim data; quality data (NCQA)	Payment Transformation Patient / Consumer Centric

AIM 13: DEFINE AND BETTER UTILIZE COMMUNITY HEATLH WORKERS

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Develop uniform credentials and license requirements for CHWs.	Integrate services within the PCMH model; include in provider directories; ensure awareness among care teams	A clear career path and opportunities for people with this credential; the creation of a pool of workers to support the expansion of value-based care.	Process evaluation and #'s of CHW's licensed or hired over time.	Multi-Payer Community Assets

AIM 14: UNDERSTAND THE HEALTH CARE WORKFORCE NEEDS OF THE FUTURE

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Conduct thorough and comprehensive workforce assessment that provides a detailed understanding of the current and projected workforce available in Rhode Island as it's needed to provide value-based care to Rhode Islanders.	Use SIM grant funding to conduct thorough assessment that will use of DLT specialists and provide the state a model to manipulate as changes are implemented	Rhode Island will identify gaps in the existing workforce and the appropriate workforce pipeline to deliver value-based care at a lower cost to its residents. The identification of gaps will allow to strategic planning and solutions for the provision of cost effective, efficient, and appropriate care	Process evaluation/TBD	Transparency

AIM 15: INCORPORATE VALUE-BASED CARE CONSIDERATIONS INTO HEALTH CARE TRAINING

Innovation/ Activity/ intervention	**How?**	**Outcome**	**How to measure outcome**	Pillars
Develop curricula for in-service training and schools. Develop coordinated curricula and programs/opportunities for previously siloed training programs to practice coordinate care in a training setting before graduating, also promote development of training programs that produce workers skilled in data analytics and interpretation	Utilize the findings of the focused assessment to identify the biggest perceived gaps for the future and work with involved parties to develop coordination programs.	Current workforce able to provide right care right time right place at the right cost for patients and their employers.	Process evaluation/TBD	Accountability Patient / Consumer Centric

J. EVALUATION PLAN

The fundamental hypothesis of Rhode Island's State Healthcare Innovation Plan is that the transition to the value-based care paradigm will improve the health of Rhode Islanders, improve the efficiency of and satisfaction in their care and result in reduced costs of care from projections. This hypothesis aligns with the goals in the plan. The determination of the plan success required identifying effective measures that are available to provide baseline data and tracking those measures longitudinally through the implementation of the plan. The following table outlines the evaluative questions (goals of the plan), metrics for evaluation, sources of data, and objectives for the metrics to provide effective assessment.

Evaluative Questions	Metrics	Sources of Data	Assessment Objective
Is the Value-Based Care Paradigm improving the health of Rhode Islanders?	Years of Potential Life Lost	CDC's Web-Based Injury Statistics Query and Reporting System (WISQARS)	Annual reductions of YPLL value
	Self-Reported General Health Status	Behavioral Risk Factor Surveillance System (BRFSS)	Annual increase in average score, Annual increase in percentage of Rhode Islanders responding "Good, Very Good or Excellent"
	Number of days impacted by poor physical or mental health	Behavioral Risk Factor Surveillance System (BRFSS)	Decrease in days impacted, with a target to reduce days to national average
	Percentage of adults who participated in enough aerobic and muscle strengthening exercise to meet recommended guidelines	Behavioral Risk Factor Surveillance System (BRFSS)	Annual Increase in percentage
	Percentage of adults with diabetes who reported receiving a foot exam in the previous year	Behavioral Risk Factor Surveillance System (BRFSS), potentially, All Payer Claims Database	Annual Increase in percentage
	Percentage of adults with diabetes who reported receiving a dilated eye exam in the previous year	Behavioral Risk Factor Surveillance System (BRFSS), potentially, All Payer Claims Database	Annual Increase in percentage

	Percentage of adults with diabetes who reported receiving 2 or more A1c tests in the previous year	Behavioral Risk Factor Surveillance System (BRFSS), potentially, All Payer Claims Database	Annual Increase in percentage
	Four Level Smoking Status	Behavioral Risk Factor Surveillance System (BRFSS)	Annual Increase of Percentages of Rhode Islanders who have never smoked or are former smokers
	Percent of adult smokers who have made a quit attempt in the past year	Behavioral Risk Factor Surveillance System (BRFSS)	Annual Increase in percentage
Is the Value-Based Care Paradigm resulting in better health care and are patients more satisfied?	Post-Acute Unplanned Care Utilization	Unplanned Care Composite Measure[1]	Annual reduction in utilization
	All-cause Emergency Department Utilization	Department of Health – Hospital Data Program	Annual Reduction in Emregency Department Utilization
	Percentage of patients satisfied with access to health care services	CAHPS Access Composite Measure	
	Percentage of patients satisfied with providers of health care services	CAHPS Provider Rating	
	Percentage of patients satisfied with communications from providers	CAHPS Communications Composite Measure	
Is the Value-Based Care Paradigm reducing costs from projected trends?	Health Care Expenditures	Medicaid Annual Cost Report, National Health Expenditures, All-Payer Claims Database	Expenditure Reductions from trend (adjusted for risk)
Is the Value-Based Care Paradigm propagating through the Rhode Island Health Care System?	Percentage of claims payments made through value-based care arrangements	OHIC Rate Review, Medicaid payment data	Increases in percentages of payments made through value-based arrangements

1. (Baier, Gardner, Coleman, Jencks, Mor, & and Gravenstein, 2013)

K. STATE HEALTH CARE INNOVATION PLAN FINANCIAL ANALYSIS

The State of Rhode Island used State Innovation Model Design funds to employ the services of the Advisory Board Company and Milliman throughout the design process. Milliman performed actuarial analysis of claims data sets to estimate the health care spending on a per member per month ("PMPM) basis, of the following populations listed in the table below. Milliman utilized many data sets in this analysis, some of which contained claim level detail. The latter data sets included:

- A complete set of 2011 and 2012 Medicaid claims
- A sample of approximately 75% of commercial Rhode Island claims from 2011
- A sample of approximately 5% of Medicare claims from 2011[1]

TABLE 21: MONTHLY BENFICIARY SPENDING ESTIMATES

Payer	Population	Population Estimate	Spending Per Member Per Month (PMPM)
Medicaid/CHIP	Adult	43,545	**$416**
Medicaid/CHIP	Child	82,122	**$216**
Medicaid/CHIP	Dual Eligible	23,326	**$1,542**
Medicaid/CHIP	Disabled/Elderly	42,593	**$1,096**
Private/Other	Individual	150,948	**$436**
Private/Other	Family	430,391	**$362**
Medicare	Dual Eligible	43,940	**$1,171**
Medicare	Fee for Service/Non-Duals	149,771	**$1,058**

Trends reflecting annual spending increases by service line and population were used to estimate 2013 PMPM spending. The state of Rhode Island has estimated the spending on each beneficiary per month as follows in Table 16 below.

The methodology for calculating this was as follows: the 2011 CMS report, "Health Expenditures by State of Residence"[2] listed $8,309 in Rhode Island health care expenditures per capita in 2009. The average annual percent growth in spending from 1991 to 2009 was 6.0%. Assuming the per capita rates have not significantly decreased or been negative since 2009, this figure suggests health care expenditures in Rhode Island will exceed $8.7 billion in 2013. If the historical growth rates continued from 2009 to 2013, health care spending in Rhode Island could be as high as $11.0 billion in 2013.

[1] Pertains to Fee-For-Service claims only and contained only Part A and Part B claims as pharmacy claims were not included in the sample. A secondary Milliman database containing Part D data was accessed to estimate prescription drug PMPMs for the SIM model.

[2] Centers for Medicare & Medicaid Services (2011). Health Expenditures by State of Residence. Retrieved (November 2013) at http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip.

The following table depicts estimated 2013 health care expenditures on a per member per month (PMPM) basis by payer group and by service category[3]:

TABLE 22: HEALTH CARE EXPENDITURES BY MONTH BY PAYER GROUP AND SERVICE CATEGORY

Cost of Care by Service Category	Medicaid PMPM	Medicare PMPM	Commercial PMPM
Inpatient Hospital	$ 70.31	$ 348.76	$ 83.08
Outpatient Hospital (total)	111.09	148.96	92.13
Emergency Dept (subtotal)	*22.30*	*26.99*	*17.76*
Professional Primary Care	16.19	41.69	31.44
Professional Specialty Care	33.71	119.25	59.59
Diagnostic Imaging/X-Ray	3.27	22.30	11.99
Laboratory Services	3.06	15.15	5.87
DME	6.73	13.18	3.87
Dialysis Procedures	0.08	0.07	0.33
Professional Other (e.g., PT, OT)	28.01	0.04	10.09
Skilled Nursing Facility	0.90	109.33	1.65
Home Health	10.38	44.39	2.73
Nursing Home	138.29	-	-
ICF/MR	3.58	-	-
Home and Community-Based Servi	36.90	-	-
Other	82.82	58.07	1.98
Professional Specialty Care	33.71	119.25	59.59
Subtotal	**$ 579.04**	**$ 1,040.42**	**$ 364.34**
Prescription Drugs (Outpatient)	41.34	162.72	76.29
Total	**$ 620.38**	**$ 1,203.14**	**$ 440.63**

[3] Estimates based on results from Milliman actuarial analysis; Includes Dual Eligibles

Estimated Cost of Investments

It is estimated that the required investment totals for all of the SHIP innovations articulated in the Innovation Section will be approximately 1.5% to 2.0% of the overall cost of health care spending in Rhode Island, or approximately $150 million to $160 million annually. These estimates are informed by Advisory Board experience, case studies, white papers, Sherlock Company benchmarks, and direct estimates of the individual components. These costs are intentionally conservative. The Advisory Board Company believes these cost estimates are conservative for the following reasons:

- The high-end of benchmark cost ranges were chosen to inform The Advisory Board Company estimates
- The costs exclude any "repurposing" of existing costs (i.e. lower variable costs from decreased utilization and/or the repurposing of clinical staff with excess capacity to care manager roles)
- The costs exclude any value-based-care infrastructure start-up costs that have already been deployed in the market
- Cost estimates were grossed up to ensure a conservative total investment was projected in the SHIP

These costs are intentionally conservative because of potential inefficiencies and unintended costs associated with the direct, initial investment in the initiatives set out in the SHIP.

The cost of this investment will be shared by providers, health systems, payers, and government. The State intends to use State Innovation Model Test ("SIM") funding to advance and catalyze the private industry's progression from today's economic and operational models to those of value-based care and increased population health management. The state anticipates that receipt of the Model Test funding and market forces will incent payers, providers and other stakeholders to share in the total investment to the extent negotiated in newly formulated value based care arrangements. The state recognizes that its role is not to prescribe which stakeholders will ultimately bear certain costs. As an example, care managers – a critical resource for population health management – may be employed by a small primary care group, a larger health system, a company operating a self-insured benefits plan, or a large commercial payer. These staffing costs will be necessary to deploy a care management strategy (a SHIP initiative), but whoever funds the expense will not be mandated in the SHIP. Ultimately, the understanding of cost-benefit analyses move parties to cover costs.

The success of the innovations put forth within the SHIP will rely on collaboration across all stakeholders within the Rhode Island market. The State intends to use SIM Model Test funding to catalyze the value based care economy. Government payers have already started to shift risk to providers through value based purchasing arrangements, readmission penalties, and other initiatives (e.g. bundled payments, share saving programs, etc.). With over half of the medical spending in Rhode Island already tied to government payers the State sees the SHIP as the opportunity to instigate transformation in its health care system. The SIM grant offers payers and providers a unique chance to take advantage of resources essential to transformation that will be made available by the State. It will both expedite the transformation and provide some financial

relief to offset costs associated with the transition from a fee-for-service to a value-based health care system.

Model Testing Summary Budget Expenditure Plan

The SIM Test grant will support health care innovation and transformation by providing immediate funding to three necessary components of the SHIP including:

1. **Grant and SHIP operations (inclusive of the formation of the RICTIC)**
2. **Request-for-proposal funding to advance SHIP initiatives**
3. **Centralized Information Technology and Analytics Support**

Personnel and Operations

Rhode Island will operationalize the SIM Model Test funding in direct coordination with creation of the RICTIC to drive the SHIP initiatives. The operational staff across the administrating body of the grant and the RICTIC will consist of approximately 18 FTEs. Ten of these positions are temporary positions that will be dedicated to creating the appropriate infrastructure to operationalize SHIP initiatives and will conclude with the SIM grant. Significant attention will be paid to incorporating knowledge transfer from the temporary FTE positions to permanent staff to ensure the continuity of SHIP initiatives. Eight FTE positions will be permanent across appropriate departments dedicated to maintaining SHIP initiative operations. Five of these permanent staff members will operate the all-payer-claims-database and three additional analysts will provide analytical support to providers and payers. It is estimated that approximately $1.0M will be dedicated to salaries and benefits for these permanent positions. The temporary positions will engage payers, providers, policy-makers and other stakeholders and administer the request-for-proposals advancing various SHIP initiatives. The temporary positions will require approximately $1.4M in salaries, benefits, and overhead, and they will expire after four years. In recognition that the pace of transformation will require technical assistance and learning collaboratives as described in this plan, the RICTIC, grant administrator, and analytic FTEs will also coordinate and collaborate across these efforts.

Promotion of Market Activity through Request for Proposal

The State of Rhode Island believes that $50 million is crucial to catalyze the health care market's move toward covering 80% of the state's population under value-based contracts within five years. In recognition that a significant portion of the foundation for this transition currently exists in part or in whole through state-wide and market place initiatives, the state will use a significant portion of the funds to expand and advance these initiatives. In accordance with the innovations illustrated in this plan, grant money will be allocated based on a strict request-for-proposal process to those with demonstrated ability to advancing the innovations of the SHIP stated in this plan, including but not limited to:

- Creation of additional collaborative care organizations (e.g. Accountable Care Organizations, Clinically Integration Networks, etc.)
- Expansion of PCMH recognition and adoption among primary care providers

- Creation and deployment of Community Health Teams
- Advancement of value-based contracting
- Deployment of intermediate intensity services to high-utilizers (in coordination with CHTs)
- Co-location of behavioral health and primary care providers and/or additional behavioral health delivery innovations
- Improvement of patient engagement
- Workforce and curricula development

Centralized Information Technology and Analytics Support

To facilitate payer and delivery transformation efforts, the state will invest in building, improving on, and coordinating across the following information technology initiatives.

1. All-Payer-Claims-Database (APCD)

One of the immediate benefits that will be apparent to multiple stakeholders within the Rhode Island health care system will be the analytical support made available related to the all-payer-claims-database (APCD). To successfully transform payment and delivery systems in the state of Rhode Island, the state will require comprehensive information on health care costs and utilization. An All-Payer-Claims-Database (APCD) will allow the state to understand how and where health care is being delivered and how much is being spent. The proposed APCD database seeks to include data on commercial, self-insured, Medicare and Medicaid populations. Data collected on the APCD will include data regarding claims, payments, providers, eligibility and de-identified patient information. Collected claims data will encompass data from a full range of services, including primary care, specialty care, outpatient services, lab testing, dental services, and pharmacy data. However, the APCD will not duplicate information being collected on the HIE. A state-operated APCD will enable Rhode Island to further the goals and objectives of the health care reform: ensure price transparency for purchasers, improve quality, improve market function and provide better information to policymakers.

Proposed expenses include hardware and software purchases, staff salaries and vendor contracts. Using market rates for staff salaries and software licensing costs, it is estimated that Rhode Island's APCD will require approximately $1.4M in annual operating expenses ($1.0M in staff and $0.4M in annual software licenses). Additional start-up costs of $0.3M are anticipated in the first year. The SHIP recognizes that certain entities within the state have already reserved dollars in their operating budgets for "super-user" analysts and other positions that may be high-utilizers of the APCD. The costs listed above do not include these expenses and are in addition to any "super-user" positions already budgeted, and intend to build upon existing competencies to further the function of the APDC for providing valuable, relevant information to multiple stakeholders.

2. Provider Directory

The State seeks to create a state-wide authoritative comprehensive provider directory to provide information on demographics, credentials, license number, NPI, specialty, insurance network participation, languages spoken, office hours, and communication preferences. The provider directory will provide relation and consistent information to state agencies, providers, payers, and the public for information on the providers of care in Rhode Island. The state will conduct a strict request-for-proposal process to technical vendors to ensure that provider directory is built to address all components necessary to provide the additional foundations needed to transform to a value-based health care system. It is estimated that the provider directory will cost approximately $0.6 million during the start-up phase with $50k to $60k in annual operating expenses.

3. Patient Portal

Rhode Island must address the challenge of managing operational costs while improving patient access and satisfaction through the initiatives to transform care delivery. A patient portal serves as a secure, HIPAA-compliant two way communication channel between patients and their providers. Some of its features include test results notification, prescription renewal, demographic changes, new patient registration, health summaries, appointment requests, electronic payments, and more.

Below is a summary of benefits to both patients and providers from establishing a patient portal[4]:

TABLE 23: BENEFITS TO A PATIENT PORTAL

For Patients	For Providers
Improves patient access and engagement in care process	Increases administrative efficiency
Enhances chronic disease management capability	Improves responsiveness to patients needs
Providers instant access to lab results and centralized prescription refills	Enhances cost savings, i.e. lower incoming calls, call-backs, and phone messages
Problem and medication list viewing	Strengthens physician-patient relationship

[4] Judi Painter, "The Patient Portal: A Secure and Easy Way To Communicate With Your Patients", Quality Improvement Organizations

Savings opportunity: Studies such as the California Healthcare Foundation's examination of patient portals have shown that there are significant savings opportunities to providers[5]. Additionally, studies show increased patient engagement and satisfaction resulting from the increased use of patient portals.

TABLE 24: POTENTIAL SAVINGS FROM PATIENT PORTALS

Provider Savings	Amount ($)
Per appointment	$0.62
Per phone call to patients	$1.75
Each lab result delivery	$2.69
Mailing cost	$0.63

A Journal of Healthcare Information Management study[6] also showed that patient portals did not result in reduced physician productivity; telephone volumes dropped significantly and patient satisfaction score were higher. The state estimates a patient portal will require $0.5M to develop, roll-out, and support end-users.

4. Single Sign-On (SSO)

As health care information technology evolves, providers are beginning to utilize multiple systems. If uncoordinated, each system can require a distinct log-in process. Rhode Island stakeholders expressed strong interest in identifying opportunities to reduce multiple sign-on processes for patient facing providers. According to a survey report from The Ponemon Institute, a single-sign-on (SSO) can significantly decrease the amount of time clinicians spend on accessing various forms of electronic medical records (EMR)[7]. In addition to improving provider productivity, a SSO will provide overall increased security and efficiency in health care organizations. On average, a clinician spends 122 hours a year in accessing various forms of EMR that require different login credentials. Findings from a survey conducted by The Ponemon Institute found that SSO technology saves clinicians an average of 9.51 minutes per day, which translates into an estimated $2,675 in savings per clinician per year. If approximately 4,700 physicians and mid-levels adopt SSO at an annual cost of $85/provider, these improvements would cost the state of Rhode Island $0.4 million annually.

[5] Emont S. "Measuring the impact of patient portals: what the literature tells us" [Internet]. Oakland (CA): California HealthCare Foundation;[2011 May] [cited 2013 Nov 15]. Available from: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MeasuringImpactPatientPortals.pdf

[6] Liederman, E.M., J.C. Lee, V.H. Baquero, and P.G. Seites. 2005. "The Impact of Patient-Physician Web Messaging on Provider Productivity." Journal of Healthcare Information Management 19;81-86

[7] Ponemon Institute Research Report: June 2011; "*How Single-Sign On Is Changing Healthcare: A Study of IT Practitioners in Acute Care Hospitals in the United States*"

Accordingly, the State will allocate a portion of the SIM grant to identify opportunities for SSO capabilities across state-run health information technology and between state-run and market-run technologies such as EMRs and CurrentCare.

Expected Total Cost Savings and Return on Investment

To measure the net financial impact of the SHIP strategy, the Advisory Board and Milliman researched numerous case studies that were similar in nature to initiatives set forth in the SHIP. Milliman reviewed findings from Case Study Research and applied PMPM cost savings percentages to the SIM model. In some instances, dampening factors were applied to case studies with atypical savings estimates based on Milliman experience. This universe of case studies was used to inform estimates of related but distinct plans being proposed in the SHIP. To account for limitations and overlap of case studies, conservative estimates were developed for each initiative, and then a summary rate was calculated to reflect a savings rate of all initiatives in the SHIP. Each payer group was assigned a unique PMPM savings estimate (listed below) informed by the case study research, Milliman's actuarial analysis and The Advisory Board Company' experience estimate savings rates are listed in the following table:

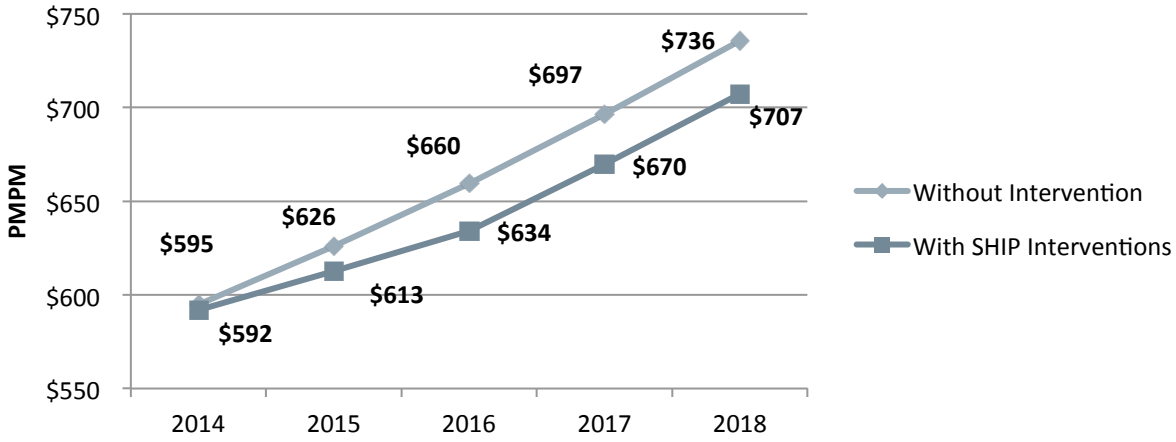
TABLE 25: ESTIMATED SAVINGS RATES

Population	**Estimated PMPM Savings** ***(vs. growth trends)***
Medicaid	*5.50%*
Medicare	*3.50%*
Commercial/Other	*3.00%*

The PMPM savings are fully realized in the financial model by the end of the third year of the SHIP implementation.

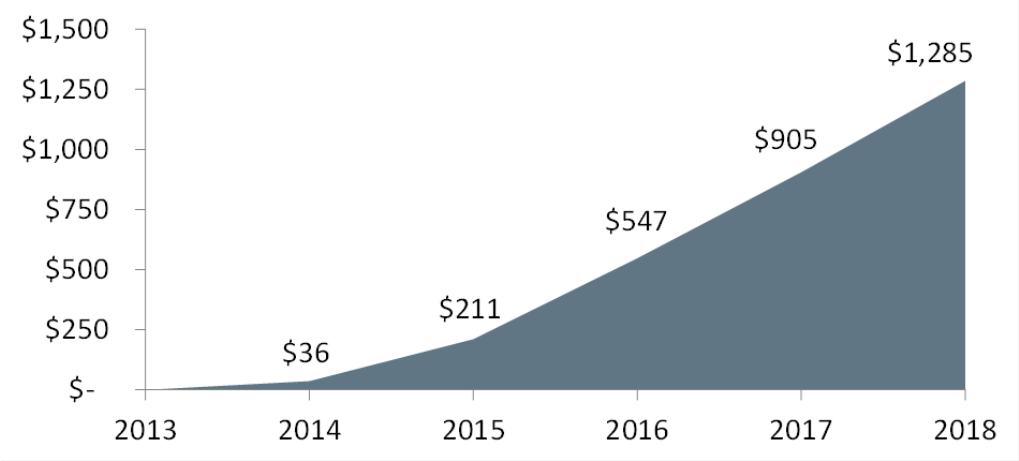
The Advisory Board Company estimates total cost of care reductions (versus the trend) of over $1.25 billion over a five year period. The primary driver of this will be increased care management that effectively reduce preventable utilization and improve health.

Projected Health Care Expenditures Trend Lines (Zoomed In)



The area between the two curves represents the total cost of care reductions. Below is a graphical representation of these projected reductions.

Cumulative Cost of Care Reduction Projections vs. Trend ($ Millions)


$1,500
$1,250
$1,000
$750
$500
$250
$-
$36
$211
$547
$905
$1,285
2013
2014
2015
2016
2017
2018

Net Annual Financial Impact vs. Trend ($ Millions)

$ Millions	Year 1	Year 2	Year 3	Year 4	Year 5	Cumulative (3 yrs)	Cumulative (5 Yrs)
Cost of Care Savings	$36	$174	$336	$358	$380	$547	$1,285
Estimated Investment Required	(152)	(158)	(159)	(160)	(161)	($469)	($791)
Net Savings	**($116)**	**$17**	**$177**	**$197**	**$219**	**$78**	**$494**

After factoring in the costs of the SHIP initiatives (estimated to be ~2.0% of health care spending annually), the net savings are nearly $0.5 billion over a five year time frame. Savings versus the trend are over $200 million per year beginning in year five.

The return on investment (ROI) after 3 years is 17%, with bulk of the return on investment occurring in the third year. After year three, the cost of care savings estimates (versus trends) take off, propelled by a value-based care economic model that is no longer in its infancy stage . The five-year ROI is more than 60%. It is important to note that conservative methodologies were used throughout the financial modeling process, including the process to estimate both the required investment to achieve the savings in addition to the projected cost of care reductions. Successful implementation of the SHIP and quicker adoption throughout the state could lead to significantly increased cost of care savings.

While the SHIP does not address nor solve all health care challenges in the state of Rhode Island, the innovations proposed demonstrate the ability to definitively slow the rapid growth of health care spending in the state. The transition from the volume-based payment models to value-based-care payment models through proven and evidence based practices will improve medical outcomes and increase patient satisfaction. In addition, this transition will incentivize stakeholders to pursue new and innovative strategies, adding value to the system for years to come.

L. DESIGN PROCESS REPORT

The State Innovation Model (SIM) Design Process in Rhode Island was conducted from April 2013 through the end of November 2013. During this time, no fewer than 35 internal State government stakeholders and 100 community stakeholders weighed in and supported the development of a vision of a near-future, value-based health care system for the residents of Rhode Island. Convened and led by the efforts of the Lieutenant Governor, Elizabeth Roberts, her staff and a group of state Directors, the SIM design process brought together participants from all elements of the Rhode Island health care system, as well as patients, advocates and journalists. The Advisory Board Company provided project management assistance and support throughout the 8-month time period.

The external stakeholder groups ranged from hospital organizations, insurance providers, community health organizations and patient advocacy groups – the commitment that these organizations demonstrated by opening their doors and sending representatives to work group meetings, was impressive and reflective of their commitment to the goal of improving health in Rhode Island.

There were six distinct activities within the Design Process, which included interviews with Key Internal and External stakeholders, the bi-weekly convening of Workstream Workgroups, a series of internal and public events, the focused State Health Innovation Plan (SHIP) writing and revision period, and the Public Tour/Comment period. The sections below provide overviews of these efforts and outcomes. Further details may be obtained in the Quarterly and Final reports submitted to the CMMI office during and after the Design Process time period.

1. Stakeholder Interviews
2. Workstreams
3. Special Events
4. Actuarial Analysis
5. SHIP Document development/revision period
6. Public Tour/Comment Period

The timelines for these activities overlapped considerably.

1. **Stakeholder Interviews**.

The Advisory Board completed more than 60 interviews with stakeholders both inside (“internal”) and outside (“external”) state government. The Advisory Board staff received a comprehensive list of the key members of the Rhode Island health care community, provided by the Lieutenant Governor’s office,

and was amended to include an additional 10 to 15 people as recommended by others. There were four distinct objectives for the interviews:

a. To help the Advisory Board consultants obtain independent knowledge of the health care community in RI;

b. To obtain and further encourage stakeholder involvement in the SIM design process;

c. To provide an opportunity to answer questions or comments about the SIM planning process

d. To collect input regarding their needs, concerns and opinions of health care reform in the State.

The interviews were structured by an open-ended interview guide that was designed to inquire about the interviewees' roles in the health care marketplace, their concerns and their needs regarding health care reform. Each interview took approximately an hour to complete, although some took longer when organizations chose to have more than one representative participate at a time. Interviewees included representatives from the State (including the Department of Health, the Executive Office of Health and Human Services, the Office of the Health Insurance Commissioner, HealthSourceRI, the Governor's Office and the Lieutenant Governor's office) as well as many groups outside of the State.

2. Workstream Workgroups

The work for the SHIP creation was divided into six categories: Clinical and Payment Innovation, Health Information, Technology and Measurement, Workforce and Practice Transformation, Community Health Initiatives, Population-Focused and Policy and Regulatory Work. The activities and considerations of each workgroup are described below. Appendix __ contains the charter statements for each workgroup, the final output or reports produced by each workgroup and a summary of the level of participation by external stakeholders.

Each workstream was led by two State staff members, who structure and facilitate the meetings. The meetings occurred every two weeks and ran for approximately 90 minutes each. The attendance in each workstream ranged from approximately 25 participants in the smaller groups to almost 60 in the larger ones.

Each workstream was responsible for identifying the key objectives that were to be included in the SHIP, as well as the key levers that will be used to achieve these objectives. While different workstreams took different approaches, ranging from presentations of best local practices on certain topics to deep

discussions of advantages and disadvantages of different practice models, each group ultimately produced a number of recommendations to the SIM team, for inclusion in the SHIP.

The following sections describe the work of the workstream workgroups, and specifically address the 14 topic requirements as outlined in the SIM Special Terms and Conditions:

1) **Clinical and Payment Innovation**

This group, which had as many as 25 members at any of its 7 meetings, reviewed and identified options for creating multi-payer strategies to move away from payment based on volume and toward payment based on outcomes. The primary method that this group used for its work was to have current Rhode Island providers and payers to present their best practices of value-based payments, as well as looking into a number of successful efforts in other states.

After considering the options currently available: pay for performance, shared savings, clinically integrated organizations and Accountable Care Organizations, the workgroup concluded that "it is necessary to encourage and support the organization of payers, physicians, hospital and other health care providers into coordinated care models." Further, the group determined that "it is anticipated that the ACO approach will be adopted by multiple payers in Rhode Island." The group identified the PCMH model, as practiced by the Chronic Sustainability Initiative – Rhode Island, to be a foundation for growth for these future coordinated care organizations.

CSI-RI demonstrated how it was formed through a state-convened coalition of providers and payers, and such a model will support the efforts of all payers: commercial and state, to effectively identify the needed structures and contracts to successfully move forward in health care reform transition. Through building upon CSI-RI's models of how to work together, share learning, identify metrics for success and use technology, Rhode Island has the potential to move most of its residents into these high quality, lower cost arrangements.

2) **Health Information, Technology and Measurement**

This group met 8 times with approximately 20 people attending each meeting. They first assessed the needs of a new value-based care system and then worked to identify where the gaps are in Rhode Island's health information infrastructure. They assessed the state of the current systems, which included:

The All-Payer Claims Database
The Health Information Exchange (CurrentCare)
KIDSNET
Unified Health Infrastructure Project (UHIP)
EHR adoption and interoperability
Provider Directory

Each was evaluated and areas for improvement were identified. These are outlined in the innovation section of this document. Throughout the eight months of the design process, it became increasingly clear that these platforms must be complete and interoperable in order to meet the needs of a value based system: longitudinal tracking of individuals, robust reporting and analysis in order to support the calculation of risk scores, accurate assessment of insurance and entitlement eligibility, measurement of spend, monitoring of risk scores to name but a few.

In order to move quickly towards capturing the savings promised by a new value-based system, it is necessary to ensure that the foundational technological platforms identified above are complete and enjoy widespread adoption as soon as possible. This is the focus of Year One activities of the Health Care Innovation Plan

3) **Workforce and Practice Transformation**

The workforce and practice transformation workstream workgroup met 8 times throughout the summer and fall, and as many as 17 individuals participated across this time period. This group had as its mission the responsibility to determine how to build a people-focused workforce that keeps the health people well, keeps the at risk population from entering into the risky high-utilizer category and supports the high utilizers in the state and helps them improve their health through lower-cost care. Additionally, this workstream worked to identify ways to support providers in their transition to value-based payment through the recognition that additional types of workers and skill sets will be needed in practices to make this kind of health care possible. This workstream considered itself to be a continuation of the efforts spearheaded by Healthy RI Task Force of September 2010, as that Task Force effort had a subcommittee focused on workforce development.

This workstream workgroup structured its work around identifying the requirements for the future workforce, the current gaps in the workforce, and identifying solutions to close these gaps. While there are some gaps in the current RI health care workforce, It became clear that the state requires a full health care workforce assessment to support adequate planning and preparation of value-based health care curricula.

An example of an identified gap identified by the workstream, based on current knowledge of licensure and value-based need, is that definition around the role, “Community Health Worker” is needed. It is also clear that Rhode Island’s current “scope of practice” statutes are appropriate for future workforce needs, with the exception of “medical assistants,” which is already being revised at the time of this writing. It was determined that there is an adequate supply of primary and specialty care physicians in the state relative to physician supply in other states. However, the extent to which new curricula is needed within local medical and allied health training is, as yet, unknown. Brown University has recently expanded its graduate Family Practice education program and has formed a partnership with the University of Rhode Island to form a new school of Nursing. There is some evidence that change in training is already

underway, but more study will be needed by the Rhode Island Care Transformation and Innovation Center.

4) **Community Health Initiatives**

The Community Health Initiatives workstream workgroup met 8 times during the Design Process period, and had as many as 65 participants from a range of organizations at any one meeting. This group chose to look at how various community based groups and local agencies or schools are currently participating in the health care system, how similar groups across the nation are participating in the health care system and how to best support the further movement of these organizations into health care in support of keeping Rhode Islanders physically and mentally healthy. This group also took time to explore how the social determinants of health, including city and town planning efforts, can be positively affected in the efforts to reform health care.

Through the presentations and discussions of this group, it was learned that these organizations had varying levels of skills, knowledge and practices with regards to managing private health information and collecting outcome data. While a few organizations already were pursuing integration with specific hospital system electronic health records, most were not. The need to provide training and support to such organizations to participate in value based care was apparent and has been identified as a key responsibility of the proposed Rhode Island Care Transformation and Innovation Center.

It is also expected that through the expansion of these capacities, these organizations will be eligible to participate in the Health Care Innovation Trust Fund sub-grant process, thereby continuing to support economic development (through additional job creation) and low-income community stabilization with attention and resources being focused on the social determinants of health. These community-based groups are the best positioned to support value-based care teams in their efforts to provide safe housing, transportation and nutrition to Rhode Island's most vulnerable populations. In this manner, it is expected that the value-based health care system will be able to support the financing and delivery of some public health services and community prevention strategies over time.

Additionally, a number of participants in the Community Health Initiatives workstream were representatives of the Rhode Island Department of Education or organizations that work within the school system. As a result of the presentation of their concerns and past success stories, the workstream recognized the importance of continuing to integrate public health concerns and the practice of health care providers into the primary and secondary school systems. While most schools in the state are too small to support the full-time location of providers within a school, the sharing of providers between schools was identified as a model worthy of consideration in the future. One such provider that might be explored as appropriate for school visits are oral health professionals, as Rhode Island is currently expanding its efforts to promote oral health in young children through the Teethfirst initiative of the Rhode Island Oral Health Commission and Rhode Island KIDS COUNT.

5) Population-Focused

The population focused workgroup focused on the potential impact of value-based care on special populations: the elderly, children, people with special needs, people with behavioral health problems and populations that suffer disproportionately due to the disparate effects of the social determinants of health. This group met 8 times during the summer and fall, and had as many as 18 participants at any given meeting.

This workstream studied the following topics: access to primary care, access to acute and specialty care, access to behavioral health care, integration of care, care transitions, continuity of care, system navigation, and information technology issues. For each of these topics, participants discussed what is currently working well, and where the gaps are. Then, participants studied how each group might benefit (or suffer) from proposed changes to a value-based care system. Based on presentations from several Rhode Island success stories in the benefits of integrated care to vulnerable populations (the elderly, and Medicaid high utilizers) – the workstream concluded that the building of Community Health Teams that contain specialized resources (for example, specialists trained in how to treat children with autism, or those with training in substance abuse) was an ideal effort to pursue, because the patient experience and clinical outcomes for these groups both require improvement.

Additionally, the value in creating co-location strategies for behavioral health patients was explored. Critical to the success of co-location practice is the understanding the different struggles that different types of patients undergo. To this end, the group recommended that to the greatest extent possible, expanding the availability of primary care at behavioral health clinics is desirable. Furthermore, providing these primary care providers with training to understand the needs and struggles of those that suffer from behavioral health or substance abuse problems is also an important factor in making this kind of intervention a success.

This group emphasized the value of models such as PACE, or the expanded Medicaid Waiver request and Money Follows the Person– recognizing that local agencies and the state need to work together to continue to develop safe, successful programs that allow vulnerable residents to pursue a healthy lifestyle with as much community support as possible.

6) Policy and Regulatory Work

The Policy and Regulatory Group met only two times during this time. This was due to the fact that it became clear that some policy questions were so narrow that an entire group was not required to pursue the answers. Rather, the model of the SIM staff reaching out to subject matter experts on specific questions was determined to be a more valuable use of participants' time. Nevertheless, as many as 20 participants were present at either of the two meetings.

Policy questions were raised throughout the SIM workstream meetings, in all topic areas. As discussed within the SHIP policy section, it was ultimately determined that Rhode Island has done an excellent job in laying the legal and regulatory foundations for health care reform, in

large part due to the work done by the 2010 Healthy RI Task Force, the leadership expressed in the creation and execution of both the Office of the Health Insurance Commissioner (OHIC) and HealthSourceRI and the continued efforts of the Rhode Island Department of Health (RIDOH) over time. For example, OHIC has already mandated a certain level of primary care spend by commercial insurance payers and HealthSourceRI plans to require the reporting of quality measures on its website in order to promote consumer engagement.

Additionally, the state has undertaken an internal assessment of how to best re-structure the health-focused agencies to support the market shift to value-based care. This is currently underway and the conclusions are not yet available. The state has a goal of aligning agencies to promote cross-agency work towards shared goals. The state also has made strides in engaging the private market in its coordinated planning efforts through the General Assembly's creation of the Health Care Planning and Accountability and Advisory Council. This Council is responsible for identifying gaps in the health care system in order to support coordinated planning over time.

Towards the end of the Workstream Workgroup meeting timeframe, the leaders of the workstreams came together for a two and a half hour "cross-pollination meeting." The goal of this meeting was to ensure that the leaders of each workstream were aware of the concerns and ideas that were being strongly considered by the other workstreams. While each workgroup was assigned to provide recommendations around a key component of the health care system, the groups often arrived at similar solutions to different challenges to creating a value-based health care system. Accordingly, the SIM staff found it important to ensure that each group was aware of the others' recommendations to this point, and to identify areas of overlap or potential discontinuity.

Following the "Cross-Pollination" meeting, one Workstream meeting (the Community Health Initiatives Workstream) was announced and opened up to participants of all of the workstreams, and a report-out on the cross-pollination meeting was presented during this time frame. A high-level overview of the Stakeholder Interview findings was also shared during this meeting. More than 80 people attended.

3. Additional Topic-Focused efforts

At times, during the eight months of meeting and planning, special internal state government meetings or discussions were held. These occurred within the SIM leadership group and some occurred within different departments or agencies, such as Medicaid. These were efforts to discuss certain topics that seemed to fall outside of the workstream workgroup efforts, but were nonetheless integral to the success of the SHIP design.

For example, the SIM leadership group discussed the expected impact of HealthSourceRI in the coming few years. Additionally, the planning for the design and launch of HealthSourceRI included the goal of the website being a place for Rhode Islanders to determine eligibility for certain state programs, as well as a place to shop for appropriate health insurance plans. HealthSourceRI expects to incorporate quality

metrics of Rhode Island health care providers and payers in order to support the pillars of transparency and accountability, and to promote informed patient engagement.

The Medicaid leaders also met in a half day retreat in September. They reviewed the early data being reported from the Milliman analysis, as well as their own internal reports. With their understanding of Medicaid innovations underway in other states and recognizing what is succeeding in Rhode Island, they decided to focus on the creation of Community Health Teams, Specialized Community Health Workers and the development Intermediate Intensity Services. They also continued the ongoing discussion of the options of how to support the further movement of Medicaid recipients into value-based care arrangements. Further discussions led to the examination of the presence and use of Medicaid supplemental payment programs. It is as yet unclear as to the potential for the use of this payment mechanism to align incentives to support the payment and delivery reform model.

4. Special Events

There were a number of special events held throughout the six-month period. Several were internal, for State SIM committee members, and several were open to the public.

- **April 2013: Presentation to the Boards of Directors of Rhode Island Hospitals by Chas Roades, on the need for and impact of health care payment reform for hospitals.**

- **April 2013: Lt. Governor's SIM Kick-off meeting: The Lieutenant Governor held a public meeting to "kick off" the SIM efforts.** She described the goals of the SIM design grant, and the need for community participation. This provided a public Q&A opportunity on the goals, and a specific request for participation in the workstream workgroups. The invitation list was compiled from the 2010 Health Rhode Island task force and was used as a starting point for invitations to participate in the workgroups related to the SIM effort.

- **May 2013: DC Roundtable: the ABC team conducted a roundtable discussion at the D.C. headquarters with the leading experts within the company, collecting their thoughts on what makes for a successful Innovation Plan as well as how Rhode Island can ensure success with these efforts.** From these early discussions came a framework that served as the foundation for Rhode Island SHIP development efforts.

- **May 2013: SIM State Leadership retreat: Leading the Transition to Value-Based Health Care Delivery and Payment Models.** This retreat was a full-day meeting attended by the SIM Leadership Committee and the Steering Committee. It was facilitated by Dick Wright, (Senior Partner) of the Advisory Board Company. Within this meeting, the leaders took the framework proposed by the DC Roundtable discussed and agreed and/or modified the input as they understood it to apply to Rhode Island. At the conclusion of the meeting, the staff had discussed and agreed upon a "Pillar" framework that served as the guidelines for all SHIP related work.

- **June 2013: Lecture on "Integrating Clinical Care" by Chris Rowe, Value Based Care Consultant at the Advisory Board.** This presentation was to the state leadership staff about the business model of Clinical Integration as a potential foundational platform for creating value-based contracts.

- **June 2013: Payment Reform Summit: This half day conference, open to the public, was on the topic of health care reform.** Mr. Roades returned to Rhode Island and gave an opening talk at the Summit while the second half of the morning was dedicated to a panel discussion (moderated by the Lt. Governor) on specific health care reform efforts to date in Rhode Island. The goal of Mr. Roades' talk was to educate the audience on the various types of payment reform underway across the nation. The participants on the subsequent panel were presidents and CEOs of various organizations, including Dr. Al Kurose, President and CEO of Coastal Medical, Dennis Keefe, President and CEO of Care New England, Gus Manocchia Senior VP and Chief Medical Office of Blue Cross and Blue Shield of Rhode Island, Lou Giancola, President and CEO of South County Hospital, Joan Kwiatkowski, CEO of PACE-RI and Chuck Jones, President and CEO of Thundermist Health Center. Well over a hundred members of the community attended the conference.

- **August 2013: Cross-pollination meeting: The objective of this meeting was to ensure that ideas generated in each workgroup were shared with the other workgroups.** The SIM Steering Committee was concerned that any given idea or innovation from one workgroup would potentially overlap or have implications with ideas and innovations being generated in other workgroups. The SIM Steering Committee wanted to make sure that these potential implications and overlap were identified before the final meetings of the workgroups, in case there was an impact on the recommendations being prepared by the workgroups. The results of this meeting were presented at an "open" workstream meeting in early September.

- **September 2013: Technical Assistance (TA) Site visit: There was a CMMI/SIM TA Visit from the National Governor Association, Centers for Health Care Strategies and State Health Access Data Assistance Center on September 10th.** The objectives of the meeting were for the TA team to provide substantive support on quality measurement and reporting, and on the topic of behavioral health integration. This meeting was attended by SIM steering committee staff and a number of additional representatives from the Department of Health and HealthSourceRI (the Exchange). The information received during this meeting supported the efforts of the SIM Steering Committee to integrate workgroup recommendations and ensure that all innovative ideas are consistent with current best practices in these areas.

5. Actuarial Analysis

The Lt. Governor's Office and The Advisory Board subcontracted with Milliman Actuarial Services (Milliman) to perform an assessment of the current health care expenditure patterns in the State of Rhode Island. Further, Milliman was contracted to produce the financial model used in this SHIP to estimate cost savings over time, as the innovations are implemented.

This effort required the identification and transfer of all relevant data from the respective Rhode Island agencies to Milliman. In doing so, it was discovered that not all cost data were available and Milliman was able to supply proxy data for some hospital charges/costs. Once the data were merged into a sufficient dataset, they were cleaned and validated. The validation efforts took a good bit of discussion between Milliman staff and SIM staff to ensure that the baseline cost and utilization numbers were consistent with pre-existing Rhode Island (primarily Medicaid) analyses. Subsequent to the validation, initial data runs were able to answer fundamental questions about Rhode Island utilization and cost patterns.

A Rhode Island "Technical Advisory Group" was formed to ensure that the analyses performed by Milliman were valid and consistent with the developing initiatives for the SHIP. By the end of the SIM grant period, they were working with the Milliman staff in the production of the financial model. The model was produced, showing an expected net savings of nearly 500 million dollars over a five year time period, and shared at a public workstream meeting on November 20th.

6. SHIP Document development/revision period

Once the Workstream Workgroups concluded, a second SIM Leadership Meeting was held in which the top innovations identified by both the SIM Staff Committee and the Workstream Workgroups were clear and able to be supported by State leadership. This was a half-day meeting held at the Rhode Island Foundation. Subsequent to this meeting, the actual drafting of the SHIP began. The first public draft of the SHIP was sent to workstream workgroup participants on October 23st. Two public workgroup meetings were held to present the draft, on the 24th of October (morning and afternoon sessions). Additionally, there was one final open workstream meeting on November 20th, where the results of the financial analysis were presented publically.

7. Public Tour/Comment Period

On November 6th, the Lieutenant Governor posted the full draft of the SHIP on her website, kicking off a 21-day public comment period. The public comment period closed on November 28th.

M. GLOSSARY

Accountable Care Organization (ACO): A health care organization that ties doctor and/or hospital payments to quality outcomes and cost of care for a population that has been assigned to them. The ACO contracts with a group or groups of providers to deliver highly efficient and effective care to its patients. The organization is accountable to the population it cares for and the payers that pay it money to provide care. If care is provided at a lower cost, the providers may share in a portion of the savings but only if quality targets are also met.

"ACO-like structures": the title "Accountable Care Organization" or ACO refers to an organization that is recognized by the federal government (the Centers for Medicare and Medicaid Services or CMS) as one that meets the definition described above and as such are eligible to treat Medicare or Medicaid recipients. There are other types of organizations that are similar in structure and goals and may mirror the ACO exactly, but they may not be recognized by the federal government. These organizations may be referred to in a variety of ways, such as collaborative care, accountable care, or coordinated care businesses. Their requirements for business operations fall under state laws as opposed to a combination of state and federal regulations for the ACO.

Attributed population or Attribution: in health care, this term refers to the assignment of a provider, or providers, to service a population of patients based on where claims data indicate the provider a member has primarily used in the past. That provider is deemed to be responsible for the patient's costs and quality of care (regardless of which providers actually deliver that care) in exchange for payment.

Bundled Payments: There are a number of terms that may be used to describe a bundled payment: episode-based payment, case rate, global or packaged pricing, and so forth. Essentially, it refers to payment to a provider or group of providers for the expected cost for a clinically-defined episode of care for certain conditions or diagnoses. This may include inpatient, outpatient or any other services rendered to treat the condition of the patient. The team of providers involved in the episode of care receive one lump sum for all needed care while individually they are paid fee-for-service for the care they deliver. As such, they are responsible for coordinating treatment within the prescribed budget while meeting or exceeding quality metrics.

Clinical integration: a network of doctors working (most often) in collaboration with hospitals. It includes a program of initiatives to improve the quality and efficiency of patient care, developed and managed by physicians, and supported by a performance management infrastructure. Clinical integration provides a legal basis for collective negotiation by independent physicians for improved reimbursement based on achieving better clinical outcomes and efficiency.

Community Health Teams (CHT): a coordinated team of often non-traditional care providers that interact or are integrated with traditional care teams like doctors, hospitals and long term care organizations. The CHT may include a nurse coordinator, social workers, dieticians, community health workers and care coordinators, or public health prevention specialists. As such, social determinants of health like housing, a person's sense of security, access to education, availability of healthy foods, and so forth can also be addressed in addition to more traditional physical and mental health. Operations

are often supported by centralized technology systems that can "talk to each other" and share critical health information among the team such as electronic medical records, provider directories, and tools for predictive modeling of the health of the population served. CHTs work well when integrated with patient centered medical homes, provider groups, and accountable care-type organizations.

Patient Centered Medical Home (PCMH) or Medical Home: A model of care that emphasizes care coordination and communication among providers. There are five functions of a PCMH: 1) it is patient centered meaning care is individualized and reflective of patient needs, culture, values and preferences; 2) care is comprehensive which means the organization is accountable to deliver a large portion of what its population needs like physical and mental health care needs, including prevention and wellness, acute care, and chronic care; 3) coordinated care means that the PCMH is responsible to the patient to ensure all aspects of their care and their providers are working toward the same goal, the patient's health. This may include hospital, outpatient or community services; 4) access to care means that patients are able to be seen when needed, experience shorter waiting times for urgent needs, around-the-clock telephone or electronic access to the care team; and 5) quality and safety are assured through the use of medicine and treatment that is "evidence-based" meaning there is clinical evidence for its effectiveness. PCMHs use systems-based tools to help in the measurement and reporting of the effectiveness of care including patient experience and satisfaction.

Risk: Today there is much discussion about doctors and hospitals "taking on risk." This means that a provider (a doctor or hospital) agrees to be responsible for the quality and cost of some or all of the care delivered to a set of patients. The risk they assume may be "assigned" to them through a contract with a payer like an insurance company or an employer. The contract may be as simple as receiving a bonus for improved quality. These arrangements are often referred to as pay-for-performance and are designed where a portion of the provider's payment is withheld or tied to performance based on process or outcome measures that are pre-determined. Some forms of risk payments may also include Bundled Payments; an arrangement where a group of providers are paid a lump sum to treat a specific condition from beginning to end, regardless of the care setting. Providers must collaborate to improve quality and reduce costs in order to receive the bundled payment. A shared-savings model is one where providers are paid a negotiated fee for their services but held responsible for the total expense for a given patient population through comparison to a benchmark or budget, e.g., the cost of care for the same population in the previous year. Providers share in savings but are not at risk for losses. Finally, capitation is a payment method that pays providers on a set amount for every member of the population they are responsible for. The payment is made on a "per member, per month" or PMPM basis. The provider in this instance is responsible for both upside (savings) and downside (losses) risk.

Shared Savings: at least part of a provider's income is directly linked to quality and the financial performance of a health plan. If costs for a specific population are lower than projected and quality is at the same level or better, a percentage of the savings is paid to the providers.

Transparency: in health care, this term refers to the sharing, publicly, of cost and quality information. It is meant to 1) provide doctors and hospitals with benchmarks for improving their performance, 2) encourage consumers and payers to reward quality and efficiency by purchasing from those

organizations with the highest quality and lowest cost, and 3) to help consumers make informed decisions about their health care purchases. It is NOT the sharing of individual or personal patient information but rather an aggregation of severity-adjusted cost and quality information of a treatment or condition by provider, geographic area, or by other demographic data. For "value-based purchasing," both quality and price information are essential to know in order to compare and make decisions. Transparency of cost and quality information has become more important as the cost burden has begun to shift to the consumer in the form of high deductibles, co-insurance or full fee-for-service in the case of the uninsured.

Value based care or purchasing: In contrast to the prevalent "fee-for-service" system of provider payment, value-based purchasing and care rewards the provider for delivering high quality, efficient care that is safe and at a low cost. Rewards, bonus payments, or shared savings to providers are conditional on achieving pre-determined goals for quality and cost. The financial incentives are designed to discourage inappropriate, unnecessary, or costly care when other equally acceptable alternatives are available.

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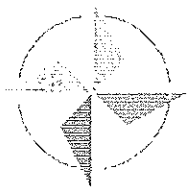
Appendix

Public Comments to the Rhode Island State Health Care Innovation Plan



CharterCARE
HEALTH PARTNERS

WWW.CHARTERCARE.ORG

December 3, 2014

The Honorable Elizabeth Roberts
Lieutenant Governor
State House Room 116
Providence, RI 02903

RE: Rhode Island's State Healthcare Innovation Plan

Dear Lieutenant Governor Roberts:

Thank you for the opportunity to provide comments on the draft State Healthcare Innovation Plan (SHIP). I congratulate you and your office for the leadership you have provided in the effort to create the SHIP. I also appreciate the work of the state agencies and the stakeholders that assisted in the development of the SHIP.

CharterCARE Health Partners has been supportive of the broad effort to transform our Rhode Island health system to improve the health of our citizens and increase the overall quality of care in the state, while also making care more affordable for all. We believe that moving from volume to value through changing the provider reimbursement system is key to transforming our delivery system.

We have recently selected a partner, Prospect Medical Holdings, Inc. (PMH), who has the expertise and capital to support CharterCARE's move to value based reimbursement in contracts with payors. A subsidiary of PMH, Prospect Medical Systems (PMS), currently manages 185,000 enrollees of health plans in capitation-based contracts ranging from medical risk to full medical and institutional risk and has done so for more than 20 years. Both PMH and PMS are collectively referred to as Prospect. PMH hospitals in Los Angeles have now contracted to assume and manage institutional risk for 35,000 Medi-Cal (California's Medicaid program) beneficiaries. Though our partnership with Prospect, we are bringing these capabilities to Rhode Island and are willing to share them with other providers as well as the payors in our community.

We have been working with Blue Cross Blue Shield of Rhode Island (BCBSRI) to develop both a more affordable small group product as required by the Office of the Insurance Commissioner and a capitation-based Medicare Advantage product. In order to build the capability to work with BCBSRI under value-based reimbursement, CharterCARE, in partnership with PMH, has established an entity capable of assuming and managing full risk

contracts when the time is right. Further, we have been collaborating with our own medical staff to create a physician group capable of assuming and managing medical risk with the contractual assistance of PMS. We have also met with most of the other organized physician groups in the community, and we are seeking effective ways to collaborate with them and provide value-based services to them. We have also met with other hospital systems and their affiliated physicians to invite them to join together in a collaborative and comprehensive network with the purpose of moving to risk-based contracts across Rhode Island sooner rather than later.

The SHIP proposes many innovations to improve our Rhode Island healthcare system. Although the ideas are good—it may be difficult to implement all of them in the near future. One of the proven concepts that is discussed throughout the document as necessary for us to develop an efficient, highly coordinated delivery system that produces quality outcomes is providers assuming and managing risk. However, we think that the SHIP has taken too cautious an approach to this important issue. While reticence to embrace a robust risk-based provider contracting model is understandable, the benefits to our healthcare system are simply too great to allow caution to mitigate the need for us to move rapidly to implement this key strategy for the provider community in Rhode Island. This is especially true now that the expertise and capability to implement this strategy is available to the providers and citizens of Rhode Island through CharterCARE's new partnership with Prospect.

It is well documented that proven innovations in healthcare take an inordinate amount of time to make their way into the community standard of care, even with solid scientific evidence and community support behind them. However, the need to implement the transition from volume to value through risk-based reimbursement to providers has never been greater, and we think that the SHIP should offer clear support for this strategic priority, including specific support for providers and payors willing to innovate in this area. Specifically, here are our recommendations for inclusion in the SHIP:

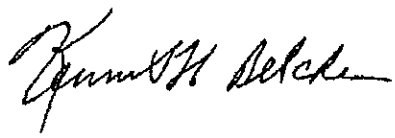
1. **Global Risk or Capitation**. The benefits of global risk or capitation in provider reimbursement should have a more prominent position in the discussion of the move from volume to value—capitation is generally referred to as something for the future. The SHIP should make clear that while these arrangements may not be prevalent in Rhode Island today; they are successfully reducing costs and improving quality in many other parts of the country.
2. **Policy Support**. The SHIP should explicitly support moving to global risk models in the near term in Rhode Island, rather than favoring an unnecessary first-step transition through ACOs, bundled payments and upside risk arrangements. These other value-based reimbursement methodologies can and should co-exist with global risk and capitation but should not be considered pre-requisites;
3. **Pilot Programs**. The SHIP should encourage provider organizations that possess the demonstrated capabilities to assume and manage global risk --financially, administratively, technologically and clinically—to do so and with the strong support of payors, government and other providers;
4. **Regulatory Support**. The SHIP should ask the Department of Business Regulation and the Office of the Health Insurance Commissioner to encourage global risk pilot implementations now for those providers and payors licensed in Rhode Island that are

willing and capable of implementing these strategies. The fact that Rhode Island's current regulatory scheme does not correspond neatly to global risk strategies should not stand in the way of these pilot programs but should be a reason to accelerate implementation for purposes of providing real-time data to the SHIP as it considers legislative or regulatory changes over the longer term.

We are in solid support of the goals of the SHIP. We also believe that the SHIP should encourage and accelerate a necessary public/private partnership to lead innovation to the more efficient, more affordable, more coordinated and higher quality healthcare system we all want in Rhode Island.

I hope you find these comments helpful as the final draft of the SHIP is completed. We thank you for the opportunity to comment and look forward to providing support to the realization of the SHIP. Please feel free to contact me with any questions you may have regarding our comments.

Sincerely,



Ken Belcher
CEO
CharterCARE Health Partners

RHODE ISLAND KIDS COUNT
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PROVIDENCE, RHODE ISLAND 02903
401/351-9400 • 401/351-1758 (FAX)

To: Lt. Governor Elizabeth Roberts

From: Elizabeth Burke Bryant, Executive Director
Jim Beasley, Policy Analyst

Date: November 26, 2013

Subject: Rhode Island's State Healthcare Innovation Plan

Rhode Island KIDS COUNT respectfully submits the following comments to the Office of the Lt. Governor regarding the Healthy Rhode Island State Healthcare Innovation Plan.

Support for State Efforts, including the SHIP

We recognize and thank the Lt. Governor, Governor's Office, the Executive Office of Health and Human Services, the Office of the Health Insurance Commissioner, the Department of Health, and HealthSource RI for their collective leadership in moving healthcare innovation and reform forward in Rhode Island. The State Healthcare Innovation Plan (SHIP) represents an important opportunity to continue to optimize and improve Rhode Island's healthcare system. We appreciate the inclusive planning process for the SHIP and have found the detailed outline of the state's current healthcare system useful. We are also supportive of state efforts to further explore ways to bend the medical cost curve, link payment to health outcomes, improve the quality of healthcare, and enhance the quality of health across Rhode Island.

Recommendation: Add a Focus on Children and Youth to the SHIP

Rhode Island KIDS COUNT strongly urges the state to consider a more robust inclusion and focus on children and youth's health care and health outcomes within the SHIP.

Children's and adolescents' engagement with the healthcare system is uniquely different than with adults. Child and adolescent health is more focused on enhancing and continuing developmental progress, while adult healthcare focuses more on health maintenance. Unlike adults, children and youth are dependent on parents/care takers and large support networks, which include family, child care providers, teachers, and others, for accessing and receiving care. Children and youth are also, for the most part, predominantly healthy, while many adults suffer from a large number of common chronic conditions (i.e. heart disease, diabetes, and hypertension). This divergence in health status has resulted in child/adolescent medical costs being significantly lower than their adult counterparts. Additionally, the combination of EPSDT mandates and new pediatric Essential Health Benefits required by the *Affordable Care Act* builds a framework of inclusive and comprehensive medical, dental, and behavioral health screening, diagnosis, and treatment for children and youth. RIte Care, in particular, has proven to be a model for setting health outcome goals, delivering quality, conducting evaluation, ensuring public transparency, and incentivizing

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as well as holding carriers accountable. These differences in benefits, carrier requirements, health status, degree of autonomy, care needed, services provided, challenges faced, and medical cost all highlight the need for a specific focus on children's health within the SHIP. Value-based payments, models of care, workforce needs and analysis, community health team membership and responsibilities, provider training and education, behavioral health services, patient engagement strategies, technology reforms, and all other proposed SHIP innovations need to take into account the perspective and needs of children, which very well may differ from adults.

It is also recommended that the SHIP explicitly analyze, account for, and incorporate the long-term savings that children's access to routine, comprehensive primary care and preventive services yields in the long run. We believe the medical cost savings produced by investments in child and adolescent comprehensive and preventive care are just as significant and may even be comparable to those found within other segments of Rhode Island's population. Furthermore, we strongly believe the savings achieved from investments in comprehensive, preventive child and adolescent care (including medical, dental, and behavioral health) is a vital and necessary component in reducing long-term medical spending. Rhode Island has had a strong commitment to children's health as represented by 94% of children having health insurance, which is 10th best in the country. We view the SHIP as an opportunity to further build upon Rhode Island's successful track record for children's health and to eliminate remaining gaps in coverage and care. Including child specific savings data and incorporating them into shared-savings arrangements will be an important catalyst for carrier and provider endorsement and change across all insurance types and will hopefully help the state achieve near universal child/adolescent coverage and care.

Recommendation: Keep the Focus on Behavioral Health

Rhode Island KIDS COUNT fully supports and welcomes the inclusion of behavioral health integration throughout the SHIP. Children's mental health is one of the indicators for which we track in our annual *Factbook* publication. The most recent-available data show a 39% increase of hospitalizations among children under age 18 with a primary diagnosis of a mental disorder since 2001. Best available data also show that in Federal Fiscal Year (FFY) 2012, 291 children and youth under age 18 with a psychiatric diagnosis were in need of inpatient treatment at psychiatric hospitals or in another placement in the community, but had to wait for one or more days in emergency departments and/or be admitted to medical floors at acute care hospitals. Also during that time, Bradley Hospital reported having an average of two kids per day who were ready to leave the psychiatric hospital for a "step-down placement" of lesser clinical intensity, but were unable to do so due to a lack of availability or lack of safe placement either at a treatment program or at home. All of this collective data show the apparent need for increased access to and integration of behavioral health care for children and adolescents. When designing or implementing behavioral health SHIP innovations, we encourage the state to take into account the unique needs of children and adolescents. We also call for the examination of pediatric and adolescent behavioral health provider capacity for both in-patient and out-patient services and that any gaps in care found, when able, be addressed through SHIP innovation efforts.

Recommendation: Add a Focus on Oral Health

Rhode Island KIDS COUNT would like to see a more robust inclusion of oral health into the SHIP. Research has shown that poor oral health has immediate and significant negative impacts on children's overall health, school attendance, and academic achievement. Despite having an

immediate and long term impact on overall health, oral health remains a siloed and optional form of coverage and care in Rhode Island's healthcare system. Efforts need to be made across all ages and groups, but especially children, to better incorporate and integrate oral health with medical care and coverage. Promotion and access to dental care and the establishment of a dental home should be included in all relevant SHIP provider and reimbursement models/innovations. The SHIP should also focus on and explore reimbursement models that increase access to dental care, especially for those children with Medicaid fee-for-service dental coverage and further maximize the pediatric dental component of Essential Health Benefits. Evidence-based prevention strategies, such as seeing a dentist by age one or soon after the first tooth erupts, should also be promoted and incorporated into relevant SHIP innovation plans, reimbursement models, shared-saving arrangements, and evaluation efforts. At a minimum, increased access to oral health should be incorporated into SHIP goal number 3 "Improve the Quality of Healthcare in Rhode Island" and should build upon the success of RIte Smiles in increasing the number of dental providers serving children with Medicaid coverage, which grew from 27 participating providers in 2006 to 406 in September 2012.

Recommendation: Keep the Focus on Health Equity
Rhode Island KIDS COUNT is very supportive of the increased focus on social determinants of health within the SHIP. Throughout the annual *Factbook,* the varying health outcomes of children and families that are associated with differing health insurance status/payers, geographic locations, race/ethnicities, and economic well-being are highlighted. All too often, the children and families with the worse health outcomes are those who either have no health insurance, live in poverty, reside in one of the four core cities (Central Falls, Providence, Pawtucket, or Woonsocket) or are of minority races and/or ethnicities. The SHIP represents a unique opportunity to reduce these persistent and long-lasting disparities with market-wide innovation reforms and initiatives. We encourage the state when designing or implementing health equity measures of the SHIP to not only focus on disparities mentioned previously, but to also include former foster youth, children with special needs, LGBT youth, and homeless and runaway youth as populations falling under this work and that their specific healthcare needs, which may be different from each other, adults, and other children, are addressed explicitly in relevant SHIP innovations.

Recommendation: Add a Focus on Evidence-Based Programs & Emerging Initiatives
Rhode Island KIDS COUNT encourages the state to leverage existing evidence-based programs and initiatives when implementing or designing SHIP innovations. Programs such as Healthy Families America, Nurse-Family Partnership, First Connections, Parents as Teachers, and Early Intervention should be considered for potential large scale implementation and inclusion within the SHIP. In addition, emerging ideas and projects such as the Department of Health's Primary Care Trust as well as the Patient-Centered Medical Home – Kids initiative, which is sponsored by the Office of the Health Insurance Commissioner and the Executive Office of Health and Human Services, should also be investigated and analyzed as potential SHIP efforts.

Recommendation: Emphasize Evaluation
Evaluation will play an important role in measuring whether SHIP innovations have achieved their stated goals of lowering medical spending, increasing quality of care, and improving health outcomes. Rhode Island KIDS COUNT encourages that the following child-specific measures are included in SHIP evaluations that focus on child well-being and health: breastfeeding,

women receiving delayed prenatal care, preterm births, low birthweights, infant mortality, childhood immunizations, children's insurance status, children's access to dental care, children with lead poisoning, children with asthma hospitalizations and emergency room visits, childhood obesity, births to teens, teen substance abuse, and children's mental health. School attendance, as well as academic performance and school-based self-reported surveys such as the *Rhode Island Youth Risk Behavior Survey* and *SurveyWorks!* at all grade levels should also be included in SHIP evaluation efforts. We believe optimal health outcomes will reflect not only improved physical health, but also improved educational performance and cognitive development and well-being. Optimal health will also be shown in the reduction of adverse measures including teen births, substance abuse, prevalence of depression, and exposure to environmental harms including lead, violence, and poverty. We acknowledge that some of these measures go beyond the traditional scope of evaluation, but emerging research has shown the high level of interconnectedness of child well-being to health, education, safety, and economic well-being indicators. As such, any SHIP evaluation effort that focuses on child well-being and health should be broad in scope and interdisciplinary in nature.

Closing

Rhode Island KIDS COUNT thanks Lt. Governor Roberts and other state partners for their continued leadership in optimizing and enhancing Rhode Island's healthcare system. Rhode Island has always been a leader in children's health and the SHIP represents a unique to opportunity build-upon this proud tradition, scale evidence-based services for children and families, minimize persistent health disparities, and reduce known behavioral and oral health gaps in care. We believe the recommendations we suggest can further enhance the SHIP. Rhode Island KIDS COUNT appreciates this opportunity to comment and welcomes the opportunity to further discuss our recommendations.

RHODE ISLAND PARENT INFORMATION NETWORK
RIPIN
1210 Pontiac Avenue Cranston, RI 02920 CALL 401.270.0101 800.464.3399 (in RI) FAX 401.270.7049 VISIT www.ripin.org

Office of Lt. Governor
State House Room116
Providence, RI 02903!
ATTN:PublicComments

November 26, 2013

Good afternoon Lt. Governor,

The Rhode Island Parent Information (RIPIN) is pleased to be able to provide comments relative to the State Health Care Innovation Plan. Thank you for the opportunity to assist your office and Rhode Island in coordinating our healthcare system.

Respectfully,

Stephen Brunero

Stephen Brunero
Executive Director
Rhode Island Parent Information Network

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1210 Pontiac Avenue Cranston, RI 02920 CALL 401.270.0101 800.464.3399 (in RI) FAX 401.270.7049 VISIT www.ripin.org

November 25, 2013

The Rhode Island Parent Information Network (RIPIN) welcomes and appreciates the opportunity to review the State Health Innovation Plan (SHIP) document and to extend our gratitude to the Healthy RI Team for the inclusive statewide collaboration from which this plan has been developed. RIPIN values the opportunity to express our support and provide suggestions and comments to assist Rhode Island in becoming the healthiest Patient Centered state!

RIPIN serves as the voice for consumers, particularly including individuals with disabilities as well as children and families. For this reason RIPIN will focus comment relative to overall vision of the SHIP plan, Community Health Teams (CHT), Patient Centered Medical Homes (PCMH) and Population Health.

Center for Medicaid and Medicare Services (CMS) issued states guidance on Quality Considerations for Medicaid and CHIP programs on November 22, 2013 at:

http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html

RIPIN will use this guidance as a framework to offer our recommendations particularly in regards to children as well as those with disabilities.

VISION

"In order to achieve this holistic framework, the state believes it is necessary to encourage and support the organization of payers, physicians, hospitals and other healthcare providers into coordinated care teams using payment models supported by the Centers for Medicare and Medicaid Services"

RIPIN would suggest weaving the consumer/patient experience as well as defining the patient as the center of health care reform. While organizing the payment and the providers is critical, it is necessary to develop health planning that recognizes the patient/person's health beginning in infancy, as the primary goal of the planning.

Community Health Teams

Indicated within the SHIP is a focus to develop Community Health Teams that will target high and rising risk populations. RIPIN suggests this model be utilized within clinical settings whenever possible to

improve integration, care-coordination, and build upon the health team model which is clearly seen in the Patient Centered Medical Home. Building from within a medical practice or working directly with the payers will enhance the ability to track data, measure and monitor the success of the model. Through the application of CMS's Quality Improvement strategies including goal setting, interventions, metrics, target, transparency and feedback, and by prioritizing provider partnership efforts from within the medical setting would serve to enhance Rhode Island's ability to experience success.

RIPIN in partnership with the Executive Office of Health and Human Services (EOHHS) and Medicaid providers has demonstrated success utilizing the Peer Navigator model and CHT outside the medical as evidenced by the Communities of Care (COC) model. RIPIN also has developed the Pediatric Practice Enhancement Project (PPEP) in partnership with Department of Health (DOH) providing care-coordination for children with special health care needs and in working within the medical setting as part of the medical care team. Both of these models have clearly demonstrated to successfully improve health outcomes for consumers as well as show financial savings.

In response to the licensure of Community Health Workers, RIPIN expresses concern that a licensure requirement may be counterproductive as it would potentially be too time consuming, and too costly as well create barriers to current successful and culturally competent programs. RIPIN recognizes the value of elevating the profession of Community Health Workers, however, required licensure at this time is felt to be unnecessary.

The success of the CHW's lie within their abilities to focus and connect with the diverse populations they serve. Alternative to licensure, the Department of Health provides a community health workers certification that is nationally recognized and can serve as basic framework for all CHW's. Any and all effort should be made to not only to financially support the process of certification, but also provide flexibility among the variety of CHW specialties.

Patient Centered Medical Home

Establishment of the Patient Centered Medical Home (PCMH) as the ***standard*** of health care delivery across all populations should be the goal for Rhode Island. Rhode Island should aim to provide ***all*** Rhode Islanders access to a PCMH by 2020. The PCMH model aligns with Rhode Island's investment in data collection and analysis, and it will transition our delivery system toward a preventative patient focused model. Every effort should be made to tool ***all*** practices toward this model of care and shift Rhode Island to be nationally ranked #1 in Patient and Family Centered Medical care.

When applying the CMS guidance to Quality Improvements, goal setting, interventions, metrics, target, transparency and feedback, PCMH can provide the launching pad for innovations, payment transformation, and public health initiatives quite effectively as demonstrated with the current state initiative CSI. Expanding upon this successful model will ensure we meet our goals as well as to become the National leader in PCMH model.

Population Health

RIPIN would oppose the proposal of a Health Risk Assessment strategy to support employers and payers to require the completion of a Personal Health Risk Assessment. The proposal should be established in a consumer oriented manner. RIPIN would suggest either a consumer incentive model or voluntary model.

Stronger focus on the children, youth, and families should also be included in the elements of innovation efforts. We understand the impact of social determinant on health, particularly for our most vulnerable populations and children. The proposed plan in its current state, should have a stronger focus on children and families. All programming and innovations should include the develop of similar programs for children with a strong public health campaign attached within the innovation.

RIPIN would also encourage enhancing curriculum development to schools, workplaces, as well as within health settings as a long-term cultural shift toward a fully engaged medical system. Developing strategies that will promote healthy beginning with our children will assist our state moving toward a Healthy 2020.

Additional comments:

- A focus to move the chronically ill or disabled into community settings should be clearly intended and thoroughly developed.
- Integration of Behavioral Health in Primary Care strategies as opposed to co-location.
- Stronger focus on workforce development that will include community based programming to transition the elderly, and individuals with disabilities toward community-integrated settings.
- Inclusion of the state Palliative Care Planning efforts to align with the health programs for the chronically ill.
- Development of state health Indicators that will allow our state to use the data to actively improve health outcomes.

RIPIN is open to offering additional information and suggestions that will assist the Healthy Rhode Island team in their finalization of the innovation plan. RIPIN is an active state partner committed to the efforts to move RI toward a Healthy 2020. RIPIN thanks the Health RI Team for their hard work and dedication to this process and constant desire to improve the health of all Rhode Islanders.

Sincerely,

Stephen Brunero, Executive Director

Green & Healthy Homes Initiative

400 Harris Avenue, Suite 202
Providence, RI 02909
P: 401-400-8429
www.ghhi.org

November 26, 2013

Mr. Daniel J. Meuse
Deputy Chief of Staff
Office of the Lieutenant Governor
82 Smith Street
Providence, RI 02903

Dear Mr. Meuse:

I have been encouraged by several colleagues to reach out to you and make the connection between the Green & Healthy Homes Initiative™ (GHHI) and the Rhode Island State Health Innovation Plan (SHIP). GHHI works to improve unhealthy and inefficient housing to combat the negative costs of chronic environmental health concerns such as asthma, lead-based paint poisoning, and trip and falls as well as energy related costs resulting from non-efficient housing.

Having recently received a draft version of the SHIP, I see many instances where GHHI could be a strong community partner to help Rhode Island create a new sustainable health system. I believe it would be mutually beneficial to meet with you and your colleagues to brief you on the work of GHHI, learn first-hand more about the SHIP, and to discuss ways we may be able to work together. Specific examples of how GHHI can help address challenges identified in the SHIP are outlined in the attached document, along with more information about GHHI.

I hope that you find these materials informative and that we may be able to connect in the near future to discuss more about how GHHI may be able to be a part of helping meet the goals of the Rhode Island State Health Care Innovation Plan.

I look forward to hearing from you soon.

Sincerely,

Mark A Kravatz

Mark A. Kravatz
Green & Healthy Homes Initiative

CC: Jennifer Wood

GHHI Contributions to SHIP Implementation

1. Challenge: Care delivery is fragmented.
   Innovation: Grow PCMH model.

GHHI has participated in local partnership discussions on strengthening the PCMH model through integration of GHHI's resident health educators, who work with patients and their families to facilitate home health, with clinical staff including doctors and nurse care managers. Through a burgeoning collaboration with Dr. Jeffrey Borkan, physician in chief of the Department of Family Medicine and Dr. David Ashley, Medical Director of the Family Care Center at Memorial Hospital, GHHI is proving that an innovative approach to healthy housing will have positive effects that spans across several systems including reducing costly chronic hospital visitations, reducing chronic school absenteeism, lowering utility costs, and stabilizing neighborhoods. In partnership with Brown Medical School, Memorial Hospital in Pawtucket, Johns Hopkins Health Care and GHHI's flagship office in Baltimore, we have recently applied for an $8.5 million Centers for Medicaid and Medicare Innovation Grant that if awarded will provide 400 GHHI housing interventions for high risk families in Central Falls (5% of CF's housing stock). This innovative and transformative primary prevention model uses housing as a platform for health to reduce medical costs associated with high-cost and avoidable home-based environmental health triggers that contribute to asthma exacerbations that result in inpatient hospitalization and emergency department visits. If awarded, this grant will build upon the learned lessons of a successful GHHI phase I pilot program in the Olneyville neighborhood in Providence that delivered GHHI interventions to 135 homes (2012-2013), Phase II in Providence (60 homes, Spring of 2014) and a Phase I statewide expansion to Pawtucket, Central Falls, and Woonsocket (50 units, Spring 2014) as well as the expertise of GHHI colleagues in 17 cities across the country.

More information about this partnership is attached as supplementary materials including the Executive Summary of the proposal and recent articles about GHHI and our partners.

2. Challenge: Care Transitions are costly and lead to poorer health outcomes.
   Innovation: Expansion of Community Health Teams will provide resources to support, coordinate and aid patient transitions from hospital to/or LTC or home.

GHHI's resident health educators have the potential to be an integral component of a health care transition team for families suffering from the effects of poor housing, such as exacerbations of asthma that result in inpatient hospitalizations, by serving to help patients returning to their homes and ensuring that home-based risks for asthma exacerbations are controlled. GHHI's reiterative in-home resident education is an essential component of assisting

patients with asthma as they transition home and come to understand the behaviors and environmental triggers that exacerbate asthma. The work of the resident health educators is complemented by the provision of household cleaning supplies and related items to help reduce allergens as well as physical improvements to the home by experienced contractors to address structural deficiencies that contribute to poor patient health.

3. Challenge: High risk population requires high intensity services and often over-utilizes the ED.
   Innovation: Community health teams based outside of provider practices

GHHI's housing interventions and associated resident education are designed to address home-based hazards that contribute to unnecessary use of high-cost medical services such as ED visits and inpatient hospitalizations. In GHHI's flagship Baltimore site, the model has proven effective with child patients exhibiting poor asthma management that result in medical utilization. For example, among 136 households that received GHHI's integrated services between 2010 and 2012, caregivers reported declines of 60% for hospitalizations and 24% for ED visits at six-months post-intervention among their children with asthma. GHHI is building partnerships in sites with MCOs and state health agencies to confirm these positive self-reports in health improvements with administrative data. As described in the attached proposal abstract, Neighborhood Health Plan of Rhode Island is one such partner that is supportive of the GHHI approach to improving patient health and is committed to data sharing arrangements that will help to verify pre-post utilization.

4. Challenge: Rising risk population requires greater awareness of risk, and access to information, prevention activities and screening.
   Innovation: Promote healthy lifestyle.

As noted previously, in the GHHI model resident health educators work in the home to help families become more aware of the housing risks as well as their own behaviors that contribute to poor health outcomes. For example, among caregivers of children with poorly controlled asthma, educators inform families on a range of behavioral changes such as adherence to an Asthma Control Plan, prescription adherence, cleaning activities, and smoking cessation, among others. Reiterative home visits by educators enables them to continue to work with families and provide needed support for health and maintaining the home intervention.

5. Challenge: Some Rhode Islanders can be disengaged and lack accountability for their own health and healthcare.
   Innovation: Provide Navigators, require Personal Health Risk Assessments, Marketing and Communication campaign, etc.

GHHI staff who work with families utilize a variety of tools and strategies designed to track outcomes and to help guide improved behaviors for personal health. In the Providence Olneyville GHHI pilot (2012-2013), resident educators implemented health and energy efficiency surveys that were used to track pre-intervention conditions and behaviors, while also using responses to the survey questions to tailor follow-up educational sessions with families. Personal health risk assessments could be implemented in much the same way.

6. Challenge: Community-based organizations vary in readiness to participate in health care.
   Innovation: Provide technical assistance services, collaboration group, empower CBOs to more directly address social determinants of health.

I am pleased to state that GHHI in Rhode Island is ready to participate in health care and has experience doing so as described in this letter. The health outcomes that GHHI seeks to improve in communities are directly attributable to the problem of social determinants of environmental health hazards, home-based hazards, and related economic inequities. GHHI is eager to be part of the solution.

7. Challenge: The state government provides little focus on or resources to address the social determinants of health.
   Innovation: Establish inter-agency education and information programs that articulate impact of social determinants of health on different agencies.

In Rhode Island we have demonstrated the ability to organize inter-agency partnership around housing and health and as described in more detail beginning on page 5. GHHI recently helped to organize the Rhode Island Alliance for Healthy Homes to align, braid and coordinate information, resources, and services for improving the health, safety and energy efficiency of all Rhode Island homes. Key Alliance partners include the Rhode Island Department of Health, Rhode Island Office of Housing & Community Development, Rhode Island Housing Resources Commission, Rhode Island Office of Energy Resources, Rhode Island Department of Human Services, Weatherization Assistance Program, Rhode Island Energy Efficiency Resource Management Council, Rhode Island Attorney General's Office and Rhode Island Housing.

What is GHHI?

GHHI streamlines housing intervention services by aligning, braiding, and coordinating partnerships representing multiple federal and philanthropic investments to provide the integrated delivery of services to low-income families in need resulting in much deeper and effective housing interventions. GHHI is a high quality, high impact approach to housing rehabilitation that drives public and private sector collaboration, streamlines service delivery, integrates energy and healthy housing interventions and develops better trained community-based green and healthy homes contractors. GHHI partner sites include 17 locations across the country with 45 communities seeking designation as "next generation" GHHI sites.

Originally founded in 1986 as the Coalition to End Childhood Lead Poisoning (Coalition) in Baltimore, MD as Parents Against Lead, a grassroots volunteer effort, the Coalition developed, implemented, and promoted programs and policies to eradicate childhood lead poisoning and further the creation of healthy homes. In 2008 the Coalition was charged by the Council on Foundations, White House Office of Recovery, HUD, CDC, EPA, DOE and the Open Society Foundations to lead the national efforts to integrate lead hazard control, healthy homes, and weatherization and energy efficiency work. This work was launched as the Green & Healthy Homes Initiative™ (GHHI). Directed by the Coalition, GHHI addresses the health and energy efficiency needs of a home through a holistic intervention model. In 2013 the Coalition transitioned its name to the Green & Healthy Homes Initiative.

The initial GHHI pilot project sites will serve to inform the national agenda by generating best practices and lessons learned in the area of integrated green and healthy housing assessment and interventions. Working in partnership with local jurisdictions and federal agencies, GHHI national has a tremendous potential to advance "whole house solutions" for environmental health, energy efficiency, and green strategies that will produce the reengineering of housing interventions and additional funding for lead hazard reduction and Healthy Homes interventions. GHHI is designed to produce measureable results that deliver healthier, more energy efficient homes, higher quality green jobs and increased economic opportunities for low income communities, and better health outcomes for children and families that results from leveraging the nation's investment in energy efficiency with critical lead hazard control and Healthy Homes interventions.

GHHI-Rhode Island Key Milestones at a Glance

- **July, 2009:** Neal Steinberg of the Rhode Island Foundation attends a White House Office of Recovery and Council on Foundations GHHI briefing in Washington, DC
- **October, 2009:** Providence is designated as a GHHI pilot site
- **April, 2010:** Providence conducts its first GHHI Providence Steering Committee meeting at the Rhode Island Foundation
- **June, 2010:** Providence attends the first annual GHHI Executive Leadership Institute in Baltimore, MD
- **November, 2010:** Providence secures $60k GHHI Onboarding grant from the Rhode Island Foundation
- **January, 2011:** Providence opens its 460 Harris Avenue office
- **February, 2011:** $3.2 million Lead Hazard Control Grant Secured (City of Providence)
- **March, 2011:** Providence Outcome Broker Hired
- **April, 2011:** GHHI Compact is signed. City of Providence is the first City in the country to sign GHHI compact
- **June, 2011:** Mayor Tavares co-sponsors US Conference of Mayors resolution supporting the work of GHHI
- **October, 2011:** City of Providence secures $850k from State Office of Energy Resources for weatherization upgrades, resident educator support, and pilot evaluation
- **November, 2011:** More than 20 MBE contractors complete comprehensive GHHI training and certifications
- **December, 2011:** Launch of Initial GHHI Providence Pilot
- **February, 2013:** Completion of GHHI Providence Pilot (135 Units)
- **May, 2013:** $2.5 million Lead Hazard Control Grant secured (Rhode Island Housing)
- **June, 2013:** GHHI Providence is host City for the National GHHI Executive Leadership Institute
- **July, 2013:** First meeting of the RI Alliance for Healthy Homes Steering Committee
- **September, 2013:** Rhode Island Foundation receives Secretary of HUD Award for Public-Philanthropic Partnerships for the Providence Phase I Pilot program
- **September, 2013:** GHHI completes first draft of its 360 page Green & Healthy Homes Rhode Island Compendium
- **October, 2013:** Public Launch of the Rhode Island Alliance for Healthy Homes

The Rhode Island Alliance for Healthy Homes

Building on a growing support for GHHI and recognizing an opportunity to expand GHHI's work to a statewide level, in June of 2013, the Rhode Island Alliance for Healthy Homes (Alliance) formed as a merger of the Department of Health's Healthy Housing Collaborative, the Housing Resource Commission's Healthy Housing Work Group, and the Green & Healthy Homes Initiatives Steering Committee. With a mission to align, braid and coordinate information, resources, and services for improving the health, safety and energy efficiency of all Rhode Island homes, the Alliance aims to provide a well-coordinated and collaborative structure to address GHHI related issues throughout all of Rhode Island. GHHI is the lead coordinating agency for the Alliance and supported by a Steering Committee representing the Rhode Island Office of Housing & Community Development, the Rhode Island Housing Resources Commission, the Rhode Island Department of Health Office of Healthy Housing, Rhode Island Office of Energy Resources, Rhode Island Department of Human Services, Weatherization Assistance Program, Rhode Island Energy Efficiency Resource Management Council, Rhode Island Attorney General's Office and Rhode Island Housing.

In October of 2013, more than 100 participants representing physicians, contractors, housing specialists, higher education, public health, energy auditors, community health workers, weatherization contractors, students, healthy homes advocates, home visiting professionals, nurses, community developers, planners, federal agencies, utilities, data specialists, construction specialists, asthma educators, and many more gathered at Rhode Island College to learn about the mission, vision and objectives for the Rhode Island Alliance for Healthy Homes.

The Alliance aims to coordinate the professional healthy homes community in Rhode Island. Value added for participants includes:

- Statewide leadership, planning and coordination on all GHHI related issues/ topics
- Healthy Housing braiding to meet GHHI standards
- Braiding of housing, health, education, and energy efficiency data
- Key reports/ documents (compendium, annual report(s), etc.)
- Professional community development/ networking
- Access to primary healthy housing leadership
- Leveraging Partnerships
    - More competitive for funding
    - Stronger policy coordination
    - Streamlining GHHI supplemental services (resident education, housing assessments, behavioral health specialists, etc.)
- Development of best practices/ standards
- Professional training, learning and development

- Coordination of healthy housing expertise and knowledge
- Communicating the story of families most in need of GHHI standard housing and raising awareness on social justice issues related to unhealthy housing

(Please see the attached materials for more information about the Alliance)

Green & Healthy Homes Initiative Asthma Intervention Model

The Green & Healthy Homes Initiative (GHHI) is an innovative and transformative primary prevention model that uses housing as a platform for health to reduce medical costs associated with high-cost and avoidable home-based environmental health triggers that contribute to asthma exacerbations that result in inpatient hospitalization and emergency department visits. Designed and managed by the Coalition to End Childhood Lead Poisoning, GHHI is being implemented in 17 communities nationally.

With an investment of $8,529,121 of CMS Health Care Innovation Challenge funds, GHHI will deliver on the three-part aim using an effective intervention of clinical referrals and follow up coupled with in-home client education, healthy housing assessment, and asthma trigger mitigation services. The program will deliver interventions to 1,750 low-income Medicaid/CHIP patients ages 2-64 in Maryland and Rhode Island. GHHI's key partners in this application include Johns Hopkins Health Care, Priority Partners MCO, AmeriGroup, Brown University's Alpert Medical School, Memorial Hospital of Rhode Island, Thundermist Health Center, Blackstone Valley Community Health Center and Neighborhood Health Plan of Rhode Island

Through the strategy set out in this proposal, GHHI and its partners will:

- Improve health outcomes for children enrolled in Medicaid as measured by the prevention and reduction of asthma related inpatient hospitalizations, emergency department visits, urgent care visits, and rescue medication use;
- Improve service delivery to high risk Medicaid populations through integrated community health practices via an expanded partnership and coordinated infrastructure of health and housing stakeholders;
- Reduce costs to Medicaid and CHIP for the treatment of asthma for 1,750 high cost burden asthma patients in Maryland and Rhode Island enrolled in the program;
- Demonstrate the viability of prescriptive, preventive CMS-funded housing interventions and the innovative GHHI model to produce long term savings to payers and CMS;
- Develop a non-fee for service payment model incorporating asthma trigger reduction services and in-home education into the health care infrastructure in Maryland and Rhode Island

With the national average charge for an asthma hospitalization for children with Medicaid at more than $8,200 and a single ED visit averaging $820, the GHHI-AIM model can significantly decrease payer costs for unnecessary, high cost medical utilization. The program, which has received actuarial certification, is designed to save Medicaid $ **952,645.40** in three award years and **$5,147,505.60** in additional anticipated savings in the subsequent two years.

GHHI and its partners will implement comprehensive reporting and evaluation measures to inform program activities and CMS in quarterly reports. Measures will be designed to inform across the areas of cost savings, clinical outcomes, quality of care delivered and patient satisfaction, as well as process measures of program activities. Through existing and anticipated expanded involvement in health care innovation activities in both locations, GHHI will also use results to inform model integration into the health care delivery system beyond immediate partners. In addition, GHHI currently partners with 17 locations nationally and more than 60 other cities have requested inclusion in the initiative, further enabling an easily scalable and rapidly deployable expansion of the model.

News & analysis at the convergence of health, science, technology and innovation

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DELIVERY OF CARE

A visit to the front lines of primary care delivery at Memorial

Training the next generation of caregivers in a patient-centric approach

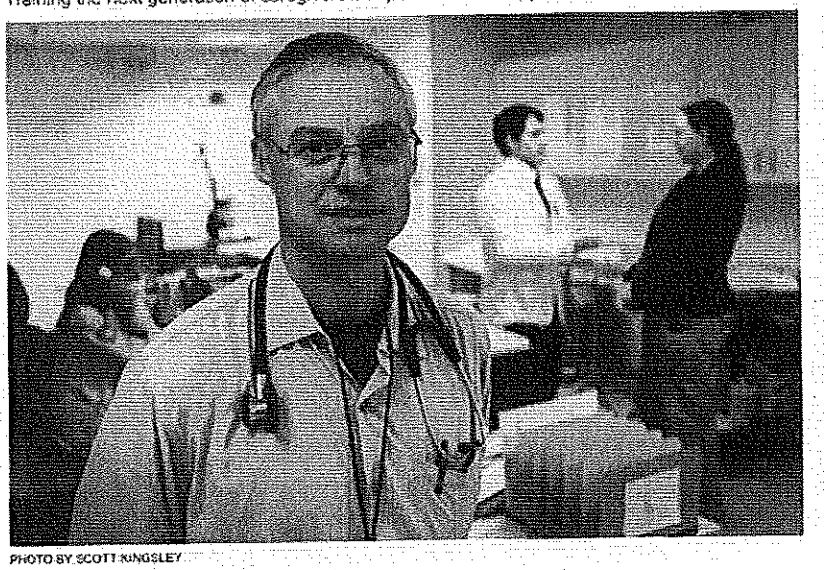

PHOTO BY SCOTT KINGSLEY

Dr. David Ashley, medical director of the Family Care Center at Memorial Hospital, believes that primary care needs to look for the root causes of health problems.

By Richard Asinof
Posted 11/4/13

WHY IS THIS STORY IMPORTANT?
The transformation of health care from a hospital-centric to patient-centric primary care model is moving ahead rapidly in Rhode Island, and Memorial Hospital is the training ground where new doctors are learning the model. Combined with the

PAWTUCKET – When Brown University re-established its medical school in the 1960s, with the hospitals as the driver, pushing a reluctant Brown to do so, there was duchy system, with each of the hospitals receiving one or more departments as a prize, according to Dr. Jeffrey M. Borkan, physician in chief of the Department of Family Medicine at Memorial Hospital of Rhode Island, now part of the Care New England hospital network.

"Family medicine was given to Memorial," Borkan said, in part because of its connection the community

Over the next 40 years, Borkan continued, as the development of specialties

network of community health centers, the new model is as much about changing health care from treating illnesses to promoting good health.

THE QUESTION THAT NEEDS TO BE ASKED

The successful growth of patient-centered medical homes will not only promote changes in the business model of hospitals, it also will force pharmacies to change their models of services, too. Why has CVS Caremark decided to launch a series of 'Minute Clinics' in Rhode Island, which detractors say is an attempt to undercut the patient-centered medical home model?

UNDER THE RADAR SCREEN

The integration of behavioral health within the practice of primary care is still an iterative work in progress, very much a learning process. A team approach – where social workers, psychologists, nurse managers and clinicians actively consult with each other -- is one way that Rhode Island can begin to address the soaring demand for behavioral health services.

grew in Rhode Island, Memorial was very much the place that kept the flame alive for primary care in Rhode Island.

"The metaphor I like to use is that [Memorial] was like a monastery during the Dark Ages, even if primary care wasn't popular, the flame was kept alive," Borkan told ConvergenceRI in a recent interview in his office. "Now, it's like the Renaissance here, we're able to expand into a system of care. And Care New England is interested in creating a system of care, not a group of hospitals."

The deal to partner with Care New England closed on Sept. 2, and Borkan voiced enthusiasm for the change. "We're thrilled to be part of Care New England."

Today, Memorial is very much at the center of the health care evolution in patient-centric primary care in Rhode Island, serving as a teaching laboratory to develop innovative approaches to team-based care. Until recently, Borkan said, "I don't think primary care was seen consistently as an economic advantage. But it is now."

The expansion of the multi-payer R.I. Chronic Care Sustainability Initiative, which began as a pilot program and now has more than 250,000 patients – one quarter of state's population – being served by practices that are patient-centered medical homes, places Rhode Island ahead of the curve in innovative health care delivery, according to Borkan.

When Memorial's Family Medicine program first sought to become part of CSI-RI, there was at first some hesitation. Borkan said he countered the resistance by arguing the importance of training the next generation of doctors in new models of care.

"We don't have, as a training site, the option of not being part of innovation and creating new models," he explained. "We are responsible for the next generation of doctors, and if we don't innovate here and begin to teach new models and be on the cutting edge of developing new models, then our graduates will not know how to practice in the new marketplace."

A recent visit from a federal evaluator of the CSI-RI program provided some national perspective of how advanced Rhode Island is in its patient-centered medical home approach to primary care.

"We're going from a small pilot to 25 percent with plans to go to 50 percent [of the state's population]," Borkan said. "No other state is doing that. This is a huge breakthrough in what we're doing here."

The actual transformation of medical practices to patient-centered medical homes is not something that is easily accomplished, because each practice is different, according to Borkan. "There is not yet a gold standard or a recipe of how to do it," he told ConvergenceRI. "At this point, expertise is being developed in the state in two places, here at Memorial and at Blue Cross & Blue Shield of Rhode Island."

Memorial is working with CSI-RI to help transform new practices that join the initiative, mentoring the practices, Borkan continued. "It's incredibly complicated and phenomenally difficult, because every practice is different and has its own dynamics."

At some point, Borkan said, Rhode Island's growing expertise in team practice may prove to be a marketable enterprise and a revenue source for Memorial – and for Rhode Island.

"Patient-centered medical homes are one piece of the puzzle," Borkan said. "We have to go from patient-centered medical homes to patient-centered neighborhoods to Accountable Care Organizations. We have to involve specialists, hospitals, and nursing homes. As part of Care New England, we can actually do that. Eventually, it has to be all of Rhode Island, and all of the U.S."

On the front lines of primary care, seeking out root causes

Dr. David Ashley, the medical director of Memorial's Family Care Center, rattles off the numbers as he gives ConvergenceRI an impromptu tour of Center's facilities. "There are about 10,000 patients, with some 39 residents, divided into three pods," he said.

Ashley, who did his residency at Memorial, graduating from Brown Medical School in 1996, has been back working at the hospital for a little more than two years. He sees the work of the Family Care Center as

changing the way that medicine is being practiced, looking at the root causes of problems, and not just treating illnesses.

"We want to keep people healthy," Ashley said. "If we an get to the root causes of things, whether it's bat poop in the belfry of someone's house that's [triggering asthma] and causing them to miss school and have multiple ER visits, then that's the dimension we have to address."

Ashley is currently collaborating with the Green & Healthy Homes Initiative to write a grant proposal to the Center for Medicaid & Medicare Innovation for a pilot project in Pawtucket and Central Falls to rehabilitate homes.

"They used to think that the root cause of asthma was asthma, and you treat that by taking your medicine," he continued. "But if we can get to the source of problems, and not just with asthma, we can improve people's health and save kejillions."

The incentives for payments will totally change, Ashley continued, if progress continues to evolve with the development of Accountable Care Organizations.

One of the expansions now underway with the CSI-RI program is CSI-Kids, which is currently struggling with developing benchmarks for wellness for children. Did Ashley have a suggestion of what the metrics might be?

"I think if there was only one thing you could measure for kids and try to figure out the best way to invest your resources, it would probably be school absenteeism," he said.

With primary care, Ashley continued, "You can't leave the social and financial conditions out of the equation. School absenteeism is often a very early indicator for problems in life. We need to investigate the reason for those absences, to find out if there are problems at home, with transportation, with health."

One of the frustrations for Ashley is the inaccessibility of data regarding the most expensive patients, data that the CEO of Neighborhood Health Plan of Rhode Island told Ashley he has but cannot share, for legal reasons. According to Ashley, the CEO said that he had the data of who the most expensive [Memorial] patients were, what their addresses were, and how much money has been spent on them in the last two years

"if we can't identify the patients, we can't assign the nurse care managers to better manage these patients," Ashley said. He said that one of his folks had called Medicaid in Rhode Island to ask for this data, and was told by whomever answered the phone that they would need to file a Freedom of Information Act request to do so.

Ashley said that if a legal way could be found to access this data from Neighborhood Health plan, it would help to better manage the most expensive patients, reducing costs, improving outcomes and help prove that patient-centered medical homes work. He acknowledged that some interventions would not work.

[While the Family Care Center has about 3,000 of its roughly 10,000 patents who have enrolled to be part of thre stat's health information exchange, Currenicare, it has been unable to send any continuity of care documents because of computer interface issues, according to Ashley.]

For Ashley, the new approach to patient-centric family is a much more satisfying way to practice medicine. Here in Rhode Island, Ashley continued, "The visionaries are in the right places. We got a great director of the R.I. Department of Health in Dr. Michael Fine. He gets it. And with Care New England, the CEO, Dennis Keefe, he gets it, he knows it, he's pushing for it."

Ashley's fear, he continued, "is that it is an experiment that may continue, because it's going to be more expensive than just having an office and a doc and a secretary."

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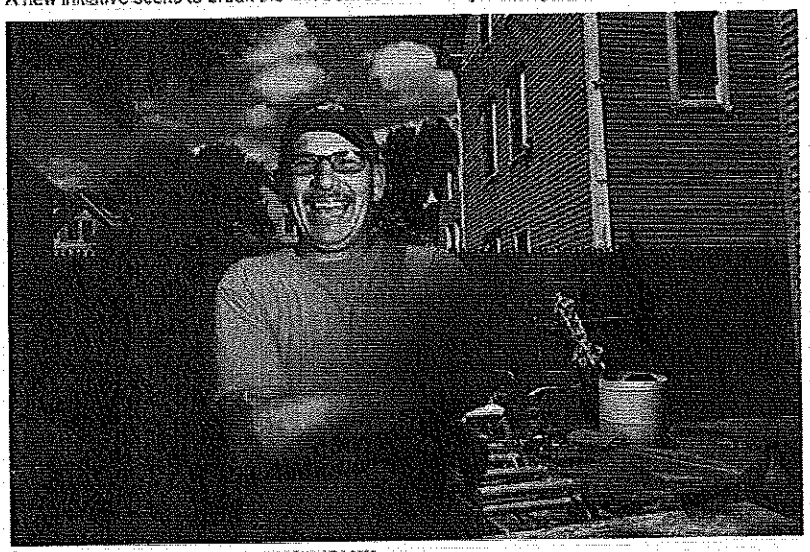
IN YOUR NEIGHBORHOOD

Good health begins at the front door of where you live

A new initiative seeks to break the link between unhealthy housing and unhealthy children



COURTESY OF MARK KRAVATZ, STUDENT INTERNS AT AS220

A contractor who was part of the Green & Healthy Homes Initiative in Providence, which renovated 135 homes in Providence last year.

PHOTO 1 2 3

By Richard Asinof
Posted 10/28/13

WHY IS THIS STORY IMPORTANT?
Investments in the best health care technology and IT infrastructure will not

PROVIDENCE - What a week it was for high profile, top-down, show-and-tell public relations events touting multi-million-dollar investments in infrastructure to support the knowledge economy and its innovation ecosystem in Rhode Island.

translate into effective health care delivery unless the underlying causes are addressed – the preventable, man-made environmental and health threats that sicken many of Rhode Island's children. Asthma is a leading cause of missed school time, lead is a major cause of poor academic performance. Their prevalence drives medical costs up and educational potential down. It's a huge economic issue. The R.I. Alliance for Healthy Homes seeks to leverage existing resources by aligning and braiding them in a comprehensive effort to focus on community solutions.

THE QUESTIONS THAT NEED TO BE ASKED

The absence of the R.I. Department of Education as a partner in this effort appears to be a problem, one that could be solved. What will it take for Commissioner Gist and R.I. Board of Education Chair Eva-Marie Mancuso to begin to address the chronic problems of lead poisoning and asthma in our schools? Health insurers are spending enormous advertising budgets to sign up new customers. Why have Blue Cross, Neighborhood, and United failed to cover asthma home visits as a reimbursable expense, even though their own data shows the prevalence of expensive interventions?

UNDER THE RADAR SCREEN

The business community has paid much attention recently to wellness programs in the workplace, promoting employee programs to increase healthy outcomes – and achieve cost savings in reducing their health insurance costs. What will motivate them to pay similar attention to wellness programs for the communities in Rhode Island? Perhaps there is a need for a new app that will calculate the direct cost of "externalities" of poorly maintained housing stock for the real estate and banking sectors.

On Tuesday, Oct. 22, the 195 Commission hosted a hardhat tour of the 20 acres of land being reclaimed after the relocation of Route 195, showcasing the work being done "underground" on connections and conduits for electric, gas, water, and fiber utilities.

On Friday, Oct. 25, Rhode Island's entire congressional delegation as well as Gov. Lincoln D. Chafee hooked up for a press conference at the Providence Public Library to celebrate the completion of Beacon 2.0, the build-out of 400 miles of fiber-optic cyber infrastructure connecting 150 anchor institutions, including universities, hospitals, research centers, libraries and K-12 schools.

Later that afternoon, Sen. Jack Reed was joined by U.S. EPA Director Gina McCarthy and Providence Mayor Angel Taveras to announce the environmental agency's support for design and construction of up to four projects in the Providence metro area to showcase what's known as "green infrastructure" to help protect Narragansett Bay and local streams and rivers from dirty water and raw sewage overflow caused by heavy rainfalls.

Earlier in the week, Reed's office had announced an additional $6 million in funding from the U.S. Department of the Interior to help Rhode Island with restoration projects to help the state prepared for future storms such as Hurricane Sandy.

Recognizing the value of human infrastructure

Yet, the low-key, bottom-up launch of the Rhode Island Alliance for Healthy Homes at a community forum at Rhode Island College on Oct. 22 may prove to be the most impressive – and innovative – "infrastructure" investment announced last week in Rhode Island. More than 100 people crowded into the lecture room at Alger Hall, participating in small breakout sessions.

The new alliance's mission is to "align, braid and coordinate" the resources of an evidence-based approach to public health with community-based energy and housing initiatives. (It was the kind of community-focused innovative approach that was "missing" from the draft State Health Innovation Plan released last week.)

The alliance is a collaborative partnership of the R.I. Department of Health, the R.I. Office of Energy Resources, the R.I. Department of Human Services, the R.I. Housing Resources Commission, Rhode Island Housing, and the Green & Healthy Homes Initiative.

The driving force behind the new alliance is Mark Kravatz, who is coordinating the initiative. He works for the Green & Healthy Homes Initiative, headquartered in Baltimore, Md., and he directed a pilot program in Providence during the last year that renovated 135 homes in the Olneyville section of Providence.

"Our work is data-based," Kravatz told ConvergenceRI in an interview following the forum. "For the 135 homes we [renovated] in Providence, we were looking at key deliverables for that work – showing a reduction in hospital visits for asthma, reducing the energy usage, reducing the chronic absenteeism in school due to asthma, and improving the health and safety of the homes."

Saving money, Kravatz continued, is an important economic piece of this work. For children with asthma, who repeatedly need treatment at the emergency room, spending a lot of money, getting prescriptions for an asthma inhaler, only to be sent back to homes where there may be many asthma triggers, which cause a repeat the cycle, drives up medical costs. "Our goal is to reduce those triggers in [the children's] homes," he said, saving money for the parents – and for the health care delivery system.

Kravatz called himself an "outcome broker," saying that his job "is to broker multiple on- the-ground resources to work more collectively."

As much as Kravatz serves as the project coordinator, he is quick to

emphasize the team approach. The Alliance's steering committee includes:
- Bob Vanderslice, from the R.I. Department of Health's Healthy Homes program,
- Nancy Sutton, from the R.I. Department of Health's Asthma Program,
- Michelle Almeida, from the R.I. Department of Health's Healthy Homes program
- Marion Gold, from the R.I. Office of Energy Resources,
- Rachel Sholly, form the R.I. Office of Energy Resources,
- Mike Tondra, from the R.I. Housing Resources Commission,
- Darlene Price, from the R.I. Housing Resources Commission,
- Greg Schultz from the R.I. Office of the Attorney General,
- Julie Capobianco from the R.I. Department of Human Services' Weatherization Assistance Program, and
- Russ Johnson from R.I. Housing.

Health care and asthma

One of the documents distributed at the community forum was a series of maps and charts breaking down the statistics for immunization, asthma and lead poisoning by school districts in Providence and statewide.

In particular, the chart, "Health care utilization due to Asthma, 2010 -2012," painted an accurate but grim picture of the number of school children afflicted with asthma in Providence – and statewide.

In Providence, 17.9 percent of all schoolchildren in pre-kindergarten through Grade 5 – 2,253 out of 12,799 – had asthma. In total, looking at children through Grade 12, 14.5 percent of all students suffered from asthma and required medical attention. Statewide, the numbers are almost as bad – 11.8 percent.

The numbers are evidence-based. They come directly from the health insurers – Blue Cross & Blue Shield of Rhode Island, United Healthcare of New England, and Neighborhood Health Plan of Rhode Island.

Specifically, "children with asthma" was defined as children who were insured by one of these plans and had any doctor's office visit when asthma was one of the top reasons for the visit or an emergency room visit or hospitalization when asthma was the primary.

Perhaps the most damning statistic was the high number – 14 percent, or 511 out of the 3,649 children with asthma – who ended up at the emergency room or who were hospitalized.

Nancy Sutton praised the efforts of Kravatz in bringing together so many people in the alliance – physicians, contractors, city and town officials – with a common interest in healthy housing.

"Within state agencies, we all have our own procedures and funding streams," Sutton said, explaining the importance of the effort. The effort to have all these agencies aligned and on the same page, working toward healthy housing, is a relatively new concept, one that she is excited about.

Since 2010, the Asthma Program has developed a evidence-based approach and home visitation focused primarily on children living in the city of Providence, Sutton said.

Working in partnership with Hasbro Children's Hospital and St. Joseph's Hospital Health Clinic, Sutton continued, when a child is seen by the emergency department and the diagnosis is asthma and they live in Providence, they automatically get a referral for a home visit.

With parental approval, a certified asthma educator, a community health worker and an environmental health worker visit the home, working with the home owner or landlord to fix and address any issues.

The program has been able to expand its efforts through a 2011 federal innovation grant from the Center for Medicare & Medicaid Innovation. Despite the program's expansion, what Sutton calls the biggest obstacle is that the commercial insurers don't cover the asthma home health visits as a reimbursable expense, despite the documentation from their own data about the incidence and prevalence of asthma – and the high cost of treating asthma through emergency room visits and hospitalization.

From the data collected over the last three years, based on health insurance claims, Sutton's program has been able to prepare a fairly comprehensive map of where asthma is most prevalent in Rhode Island. [See graphic] Not surprisingly, the heaviest concentrations are in the state's core urban areas, with the oldest housing stock.

"We don't know exactly what causes asthma," Sutton said. "Not one thing causes asthma." But, she added, "We know what can contribute to making asthma worse – mold, mildew, second-hand smoke, air pollution." And, preliminary data from the asthma program has shown that home visits and interventions have cut down on the number of emergency room visits and hospitalizations.

"We've seen significant reductions in night-time symptoms," Sutton said. "We've seen significant

improvement in sick visits to primary care providers." And, according to self-reported data, Sutton continued, "there has been a drop in the use of emergency rooms due to asthma."

Connecting the dots, leveraging resources

If you look at the composite map detailing the incidence of lead exposure, asthma, childhood poverty and older housing that was distributed at the R.I. Alliance for Healthy Homes forum, it's no secret where the problems are located.

What's been missing in the past is a coordinated effort to develop a community-based solution, leveraging existing resources. The R.I. Alliance for Healthy Homes is the kind of smart collaborative approach that many business and government leaders advocate but never implement.

Kravatz said that conversations are now underway with the primary care physicians at Memorial Hospital to enable them to write health and safety prescriptions as part of a model pilot program serving the residents of Central Falls and Pawtucket, to conduct health safety audits.

Related

Explaining the Green & Healthy Homes pilot project in Providence

UnitedHealthcare
A UnitedHealth Group Company

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November 26, 2013

Office of Lt. Governor
State House Room 116
Providence, RI 02903
ATTN: Public Comments

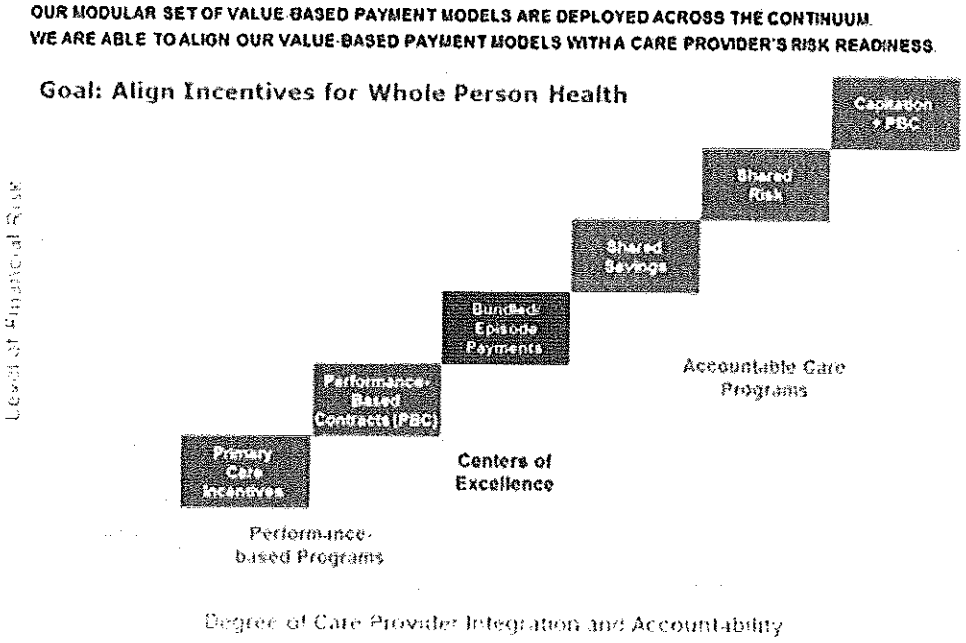
Dear Lt. Governor Roberts:

UnitedHealthcare appreciates the opportunity to have participated in the workgroups in connection with the Rhode Island's State Healthcare Innovation Plan and would like to take this opportunity to provide our support and comments on the draft plan. UnitedHealthcare is committed to the development and testing of new integrated models of care, effective payment reform, quality improvement and encouraging practice transformation. Nationally and locally, we have made substantial investments in medical home and accountable care models and other value based incentive programs. We have direct experience in contributing resources to provider practices that have demonstrated a commitment to transforming these into high value, efficient primary care setting that employ care teams and practice population management. We fully understand that partnership is required during the design and development of Rhode Island's Healthcare Innovation Plan and look forward to further engagement with Rhode Island in this effort. Furthermore, we would like to propose a meeting to discuss certain aspects of the plan, such as potential duplication of services, funding, interactions with existing models and the structure and functions of RICTIC.

TARGETS FOR TRANSITION TO VALUE BASED CARE

The State has asked for comments on targets for transition to value based care and how it can be phased in over a 5-year target period. Practice transformation takes time. Providers need to be rewarded based on their readiness and capabilities. Stakeholders need the ability to develop a suite of value-based contracts that complement and assist providers as they move across the continuum of risk. Provider readiness is individual. We cannot expect every provider to move along the continuum at the same rate or attain the highest level in a pre-defined period of time. For payment reform to be successful we must account for varying levels of risk and integration and develop programs that encourage movement along the continuum at varying rates. It is also important to consider the standardization of certain quality and outcome measures along with how these are ultimately operationalized in the service delivery system. These quality and outcome measures are the basis for any payment reform strategy. Payment reform methodology and roll-out will be

important to consider as it is important that free market dynamics are tested and developed. In other markets we have deployed a continuum of options to support movement to value based care:



We would like to further consider the impact to the market if the state as a payer mandates ACO like structures for pre-defined populations. We believe reform will be more successful if the initiatives encourage providers to deliver high-quality care more efficiently, with a specified mix of strong performance incentives that reflect the market structure and capabilities of the local community. Mandating ACO like structures may accelerate unintended provider consolidation, impact pricing and market choices. In addition regulatory changes focused on benefit design that encourages but doesn't support members staying within a defined network may dilute the desired quality outcomes and the savings impact of ACOs. The proposed plan is encouraging significant market changes and the market needs to have multiple tools available to implement and evaluate changes.

In considering Medicaid managed care transitioning to ACOs, the current managed care contracts and risk sharing arrangements between the State and the Medicaid health plans do not easily permit sharing of risk with a provider organization. To effectively implement ACOs in the Medicaid space, the State would need to reevaluate its risk sharing requirements and possibly eliminate them. UnitedHealthcare is also unclear how the ACO would be implemented with the Federally Qualified Health Centers (FQHCs) who are the primary care managers of a significant portion of the Medicaid population. We would ask the State to share their thoughts as the FQHCs are a key driver of quality and cost outcomes for the Medicaid program.

CARE TRANSFORMATION AND INNOVATION CENTER

The proposal introduces the concept of developing an entity, Rhode Island Care Transformation and Innovation Center (RICTIC) to provide assistance and support to stakeholders during the next 5 years. Given the majority of solo, 2, & 3 physician practices as opposed to large medical group in the state, to transition 80% of the state's population to value based payment and ultimately global risk, many of these small practices will need significant assistance and resources to transform themselves.

COMMUNITY HEALTH TEAMS

United Healthcare supports the use of Community based care teams that promote transparency and collaboration in the care and treatment of the patient. United Healthcare has taken a leadership position in many markets with the successful deployment of innovative clinical engagement strategies that accompany financial incentive strategies. These strategies leverage technology and engagement with physician practices to reduce fragmentation of care and the resulting cost that burden the system.

The State has identified care transitions as a challenge; historically inadequate care transitions are costly with poor health outcomes. A component of the proposed solution is the expansion of Community Health Teams (CHT). To better evaluate the use of CHT in Rhode Island we need to understand the specifics of how the population for this program will be defined and engaged. We see the value of CHTs working with hospitals, providers and MCOs in health education programs, residential visits, nurse and social worker interventions, drug programs and other programs already in use for these patients. CHT teams should leverage and not duplicate services available in the community currently.

One possible model would be to align the CHT's with practices so that we are not creating separate entities. The funding of CHT's must be aligned with clinical and quality outcomes as well as medical cost savings. The CHT teams need to be aligned with the providers who are closest to the patients and so that they have joint accountability for quality, clinical and medical outcomes. Workforce development, training and oversight of these teams is a key component.

POPULATION HEALTH TARGETS

The plan does not lay out sufficient details on how the current CSI and various CMS models already in place in the market will interact with expansion of value-based structures outlined in this proposal. Without a clearly articulated approach, there is a risk of duplication of resources and efforts as well as a risk of conflicting goals undermining each initiative.

While the goal to improve primary care is a worthy one, it's important to step back and apply lessons learned from the current CSI program. UnitedHealthcare's experience recommends the following considerations:

- Requiring additional guaranteed fee payments to primary care providers risks creating an unintended consequence of higher inflation in total cost of care

- Incentives and payments ought to be structured so that providers are held accountable for transformation to achieve higher quality, more efficient care

BEHAVIORAL HEALTH STRATEGIES

Co-location of Primary Care and Behavioral Healthcare is a strong principle that has merit in transforming our care system and has shown positive member outcomes in our experience. The focus on FQHCs and Community Health Centers may create some financial challenges that need to be addressed. Transition of services from BHDDH to EOHHS and the Medicaid managed care organizations as part of Medicaid Expansion and the Integrated Care Initiative is an initial step in better coordinating medical and behavioral care, co-location or virtual co-location is a possible next step.

Thank you for the opportunity to review and comment on the Rhode Island's State Healthcare Innovation Plan. We look forward to continuing to work with you throughout this process, and greatly appreciate the opportunity to continue our dialogue.

Sincerely,

Stephen J. Farrell
Chief Executive Officer

Patrice E. Cooper

Patrice E. Cooper
Executive Director
Rhode Island Community Plan

Rhode Island State Healthcare Innovation Plan

Rhode Island Department of Health Public Comments

These comments are made in the spirit of a process that has been open and positive throughout, for which the Rhode Island Department of Health is most grateful.

The Rhode Island State Healthcare Innovation Plan (SHIP) draft has been developed in a context which challenges everyone's ingenuity, and is precipitated by the continuing escalation of the cost of medical care beyond both the rate of inflation and the growth of gross domestic product. This cost trend cannot long be sustained, yet will persist both despite and because of the workings of the Patient Protection and Affordable Care Act (ACA).

The parameters set by the terms of the grant, by its funding scale and by the need to successfully compete with other states' proposals can argue for a practical approach. While this practical reality is acknowledged, we also urge that the unique opportunity to pilot, test and establish genuine innovation offered by this grant be maximized.

The Rhode Island Department of Health's (HEALTH) recommendations focus on five pillars: governance; achievable and meaningful cost control goals; mental/behavioral health and substance abuse; public health goals and objectives, and support of the primary care delivery system.

I Governance

The process of creating adequate accountability requires a central governance structure. We advise caution in assuming that providers can or should be held accountable for the health of an attributed population (SHIP draft page 38) – at least until there exist large vertically integrated provider and risk bearing organizations that have an infrastructure that is robust enough to managed that care.

Rhode Island is very far from having organizations of that size, and from the perspective of critical mass likely lacks the population size to support even one such organization. But even supposing we could support one or two such organizations, they are unlikely to evolve within the three year period of the grant.

Rhode Island's providers already work diligently to maintain service quality for the services they do provide. Until large vertically organized organizations evolve or move

here from other states, we should better develop a process to determine what outcomes we wish to achieve, what services are necessary (given our existing health status and demographics to achieve those outcomes), and what prices we are willing and able to pay for those services. Then we can institute oversight of those services, their quality, and their costs, to ensure that the services we decide to purchase are provided as promised, and to ensure that those services create the health outcomes projected.

Additional analysis of service delivery planning will strengthen the confidence level of the projections outlined in the SHIP Financial Overview document. The Advisory Board Company has clearly described the market's perception of the absence of clear command and control in state government vis-à-vis the health care sector, which will remain a challenge going forward

II Rising Costs and Sustainability

The actuarial consultants estimate that the SHIP will realize cost savings over three years of: Medicaid 5.5 percent; Medicare 3.5 percent; Commercial 3.0 percent for an aggregate saving rate of 3.8 percent compared to the current cost inflation trend. While all the interventions can work as described, they must overcome some considerable challenges to achieve the necessary rate of scalability.

To measure cost savings, the SHIP could be strengthened by adding a comparison to current cost savings to the analysis. Since it is projected that real costs will go up despite savings (approximately 4 to 6 percent, given a certain degree of predictive variation in the ACA newly insured population), it will be useful going forward to have this additional way to track success and challenges

The SHIP can also be strengthened with a view that encompasses delivery system changes in surrounding states, and the impact those delivery system changes are likely to have on the Rhode Island health services delivery system and on the Rhode Island economy. The anticipated strengthening of hospital infrastructures in surrounding states, (and the lead that those systems have in developing vertically integrated systems of care compared to Rhode Island), is very likely to result is a strong entrance of one or more of those systems into the Rhode Island market. The SHIP should take cognizance of the potential effects of such a development, for example on Rhode Island jobs in health care management and tertiary care, and on state and local capacity to influence our own health services delivery system.

The challenge for Rhode Island is to drive down our costs more quickly than surrounding states. By doing so are we going to be able to rebuild our economy and protect local control of health services decision making, understanding that a strong and equitable economy is likely the most significant predictor of positive public health outcomes.

HEALTH recommends that considerations regarding cost savings focus on four challenges: self insured employers, mental and behavioral health; broader utilization of CSI; and the primary care avoidant population.

Self-insured employers: represent 43 percent of the commercial market. The SHIP should define a methodology to include them in a multipayer process to help reach the challenging goal of including 80 percent of Rhode Islanders in value-based care arrangements. HEALTH has assembled a multiple agency working group that includes representation from the General Assembly and the Governor's Office to find a solution to this challenge. We strongly suggest that some of the grant funds be used to address this issue.

Mental / Behavioral Health and Substance Abuse. The costs associated with mental/behavioral health and substance abuse strongly indicate that these issues must be addressed vigorously. The co-location of mental health providers with primary care practices, independent of other integration reforms, has been proven to be a limited strategy. There is good integration science, and the best findings show that only capitating practices to provide both primary care and mental health is likely to be effective. Integration in and of itself is also a limited approach for substance abuse treatment; a more concrete and comprehensive strategy than that detailed here would be well-taken.. Reforms that could be considered include: recovery centers in every community; multidisciplinary non-narcotic chronic pain treatment centers; emergency department (ED) diversion to substance abuse treatment centers; highly developed medical assisted therapy options; and robust inpatient hospitalization and treatment for patients who are substance addicted, and who require special skills for their medical management and mental health issues.

The Broader Utilization of CSI. The descriptive information (but not the financial model) places considerable emphasis on the spread of the patient centered medical home (PCMH) model and of CSI. While this can represent a step forward, we caution against overdependence on the PCHM model as a basis for cost control. The original practices were early adopters and were the most likely to become proficient at population health management. There remains considerable room for improvement and growth in those practices in terms of population health management and treatment to goal. The remaining practices that have not adopted PCMH are unlikely to do so, or are less likely to become as adept at population health management.

Primary Care Resistance. At least 12 percent, but perhaps as many as 30 percent, of the population is primary care resistant (individuals who have health insurance but don't use primary care for the bulk of health services). This population, who don't want to become activated patients, together with 50,000 or more of the remaining uninsured (based on projections from HealthSourceRI), will continue to drive cost and increase morbidity. The SHIP could be strengthened by that addressing this key population. Recognizing the importance

of this factor, health policy experts as diverse as David Satcher, Paul Grundy, and Kurt Stange have become supporters of the Primary Care Trust, which is designed to achieve the goal of primary care for the whole population, and is why Tom Bodenheimer has written extensively on the limitations of PCMH.

III Mental/Behavioral Health and Substance Abuse

As stated above (as shown on the graph on SHIP draft page 32), many of our cost and outcome challenges involve mental and behavioral health, and substance abuse. It is important to recognize that the single most significant contributor to years of preventable life lost in Rhode Island is prescription drug overdose death (note, however, that IV drug overdose death appears to have recently eclipsed prescription drug overdose death in the near term). The innovation proposed – the co-location of mental and behavioral health and primary care – has been tried repeatedly, and its limitations are well known. It is key to institute a full methodology to address substance abuse treatment issues, perhaps the single greatest health care challenge we face. The SHIP could be significantly strengthened by incorporating additional mental/behavioral health and substance abuse treatment infrastructure proposals.

IV Public Health Goals and Objectives

The section on Healthcare Goals (SHIP draft page 35 et seq.) conflates goals, strategies and tactics; quality with outcome; and healthcare with health. The section replaces an epidemiologically driven and precise goal-setting process now run by HEALTH with the many) goals in Healthy People 2020 and in the Center for Disease Control and Prevention's "A Million Hearts" initiative, while making reference to American's Health Rankings. As a result, it is difficult to analyze the overlapping and constituent indicators of each.

HEALTH notes that there is no evidence-based intervention to reduce preventable hospitalization within the draft. We believe that the reduction of preventable hospitalization requires a multipronged approach, and should include changes in provider behavior, improved primary care access, and regulatory changes.

HEALTH's approach to measure goals and objectives uses instead a consideration of Years of Potential Life Lost. We also intend to use Per Member Per Month (PMPM) cost; Days of Lost Work and School, and Indicators of Social Capital when good indices for the latter three measures become available. We have a particular focus on eliminating health disparities on the basis of race, culture, language and physical ability, a focus entirely absent from the SHIP proposal.

We have recently turned our attention to three indicators from American's Health Rankings, but have not yet set targets for these three: preventable hospitalization, binge drinking, and sedentary life style. A further selected list of leading health indicators that should be reviewed, but which do not yet have Rhode Island targets are in the notes. [1]

The SHIP would be strengthened by addressing a precise methodology to achieve public health goals. It does not specify or fund the use of the quality assurance process in primary care practices, a particularly promising intervention which should be supported by the grant.

V Support of the Primary Care Delivery System

Although the Financial Overview does not detail the funding methodology for extra community services, like Community Health Teams (CHT), the dollar amount suggested in presentations about the financial model was $12 PMPM. That number, which is very close to the current full spend on primary care in Rhode Island, would be used to create another service delivery model, and create more complexity in an already overcomplicated delivery system array of market actors. More importantly, this innovation diverts funds that could be used to directly support primary care practices.

In the last twenty years, primary care practices have lost income once earned form attending patients in the hospital. They have lost income as immunizations have move to mass immunizers and pharmacies. They have lost income form urgent care. They have lost income from the provision of laboratory services. They are likely to lose volume and income from routine sick visits, as retail pharmacy clinics gin a foothold in Rhode Island. They have lost income to electronic medical record (EMR) providers while we made their practices and lives endlessly complex by requiring EMR use.

HEALTH suggests that resources such as those earmarked for CHTs are better targeted to strengthen primary care and authority structure.

Additional Comments:

The Definition of "health"

Applying the World Health Organization's definition of health, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" in the draft SHIP proposal sets a standard which fundamentally undermines the ability to measure success in achieving public policy objectives. The definition was adopted in 1946 [2] and is not a measurable standard. While its breadth seems to accommodate setting goals that encompass social, behavioral and environmental determinants of health, the ideal of "complete," and the lack of measurable criteria invites an unfocused implementation of the plan, and a lost opportunity to fully measure success or adequately measure progress.

A definition of health that has achieved some attention in the health policy community and is measurable is: "health is the biological, social, and psychological ability that affords an equal opportunity for each individual to function in the relationships

appropriate to his or her cultural context at any point in the life cycle and/or the equal ability to participate in the democratic process." [3] (Other similar definitions are reviewed in Stange, K. Power to advocate for health. Ann. Fam. Med. 2010 March; 8(2): 100–107).

The SHIP draft would be strengthened with a refined definition of "health." Distinctions between individual health, public health, relief of pain, fulfillment of personal desires or goals, and life extension are often conflated and otherwise confused in the public mind, In order for the public and private payers alike to best target scarce resources, we need a definition that allows us to purchase services in the public interest – services that allow individuals to function in the marketplace and in the democratic process as effective agents of their own self interest. An inadequate definition will continue to enable market dynamics that create profit at public expense by selling health care goods and services to improve an entirely subjective sense of well being. We can no longer afford this kind of health care environment.

Multi-Payer Model and Costs

Broadly defined, the various initiatives in the SHIP advance the practice of managed care. While these latest iterations of managed care can and will do a better job of managing actual care and not just costs, we are at the point where the cost tread will produce an access crisis. In this light, care itself, and not just well managed, high value care, can be seen as the fundamental issue to address. Substantially reducing administrative costs -- which are currently over 30 percent -- should be an integral part of at least one pilot innovation. After all, administrative costs add little or no value to the health care system, whether value is measured in patient care or in patient outcomes. That is certainly true of unnecessary administrative costs. The Primary Care Trust is an innovation that would aggregate monies already in the system, simplifying and streamlining claims processing and billing procedures alike, and should be supported by the grant.

Health Information Exchange and CurrentCare

The SHIP proposes to allocate grant monies to the expansion of CurrentCare. The goal of a more extensive and therefore robust information exchange is well taken; both private medical practice and public health can and will benefit from a robust HIE. But the draft fails to address the key impediment to achieving significant enrollment expansion in an expeditious manner. A model well tested in other states (that would be an innovation if adopted in Rhode Island) is an Opt-Out system. Resources to convert from our Opt-In model should be part of the funding request.

Community Health Teams

Community Health Teams have been tested in places such as Vermont where the population is less dense than Rhode Island's, but it's not clear whether these CHTs will be effective in an urban environment. As discussed above, CHTs will, however, divert considerable resources that could be used to build actual PCMHs that can function as public health engines.

Focused care-coordination of people at highest risk has been used effectively in places like Camden, New Jersey, but its use has not been integrated well into Patient Centered Medical Homes. It is not clear how a segregated approach to the highest risk will impact the primary care ecology.

Hospital System Failure

Approximately 40 percent of global medical costs are incurred by hospital care. The state has determined that Rhode Island has excess capacity of some 200 beds. It is also estimated that $100M per year could be saved if the excess capacity was trimmed through hospital closure. The SHIP draft, while projecting to achieve much of its savings by averting hospital utilization, could also incorporate a mechanism to achieve this additional path to cost savings.

Applied Savings

The SHIP proposes to accelerate the transfer of risk from payers to professional providers and to hospitals; but it is unclear exactly how the money, whether accounted for as an investment or as a saving, will be returned to the providers in a "reward system

Savings should be re-invested in two ways: to pay primary care practices to do QA/QI of public health educators, which we know will lead to improvements in public health. The second way is to spend the savings on education, housing, the environment, and public safety, all of which also have a positive impact on the public's health. It is only by redirecting medical resources to improve these factors that we can possibly achieve the better outcomes for less money that obtain in other countries around the world.

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[1] **Selected Healthy People 2020 Health Indicators**

Access to Health Services

Increase the proportion of persons with a usual primary care provider (AHS-3)

Baseline (US): 76.3 percent of persons had a usual primary care provider in 2007
Target (US): 83.9%

Nutrition, Physical Activity, and Obesity

Reduce the proportion of adults who are obese (NWS-9)

Baseline (US): 33.9 percent of persons aged 20 years and older were obese in 2005–08 (age adjusted to the year 2000 standard population)
Target (US): 30.5 percent

Reduce the proportion of children and adolescents aged 2 to 19 who are considered obese (NWS-10.4)

Baseline (US): 16.1 percent of children and adolescents aged 2 to 19 years were considered obese in 2005–08.
Target (US): 14.5 percent

Tobacco

Reduce cigarette smoking by adults (TU-1.1)

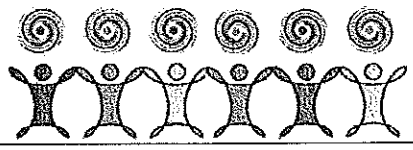
Baseline (US): 20.6 percent of adults aged 18 years and older were current cigarette smokers in 2008 (age adjusted to the year 2000 standard population)
Target: 12.0 percent

Reduce the use of cigarettes by adolescents (past month) (TU-2.2)

Baseline (US): 19.5 percent of adolescents in grades 9 through 12 smoked cigarettes in the past 30 days in 2009.
Target (US): 16.0 percent

[2] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[3] The Nature of Health, Fine and Peters, Radcliffe Publishers, 2007.



COMMUNITY HEALTH INNOVATIONS OF RHODE ISLAND

26 November 2013

Dear Healthcare Reform Committee,

We at Community Health Innovations of Rhode Island (CHI-R), the State's leading Community Health Workers' program for community-centered workforce and leadership development, thank you for the opportunity to give comments on the draft State Health Care Innovation Plan (Plan). To start, CHI-RI is pleased that social determinants of health (SDH) takes a prominent role in the Plan. The articulation of SDH in the plan coincides well the newly formed Commission of Health Advocacy and Equity. This commission requires a cross-section of state agencies and community members to focus on the social determinants of health to better the health and well-being of the state. The specific focus of SDH in the Plan will also place Rhode Island to fully participate in the new national conversation on SDH from the American Public Health Association (APHA) to the Institute of Medicine (IOM); see *For The Public's Health* series of reports Dec 2011 to April 2012.

The fact is that no matter how good health care delivery may be without attention to the physical and social environment that may make people ill in the first place disserves us all. In spite of our state's decade and over better access to health insurance as compared to the rest of the nation, noted in the Plan, RI has not fared better than the rest of nation in ending or decreasing health disparities across socioeconomic and racial demographics. Considerable evidence that social and economic conditions, apart from access to and quality of medical care, which have undeniable importance, play a fundamental, powerful, and pervasive role in the health outcomes of preventable diseases. It is most likely that it is the social disparities in RI many of which are noted in the Plan that must be attended to if we are to improve our general health status. Thus the articulation of SDH in the Plan will allow greater recognition that health comes about from where we live, learn, work, and play. Our neighborhoods and communities are ultimately more important then our genetic code and is what we must also focus on to achieve better health outcomes in RI. This in the end should decrease costs and yield efficiency and prosperity. Thus the goal to focus on SDH sets Rhode Island on the path for a more integral understanding of health and that clinical care is only one part of how we take care of ourselves.

We were also very pleased that the draft Plan appropriately makes direct, and even more indirect, references to the value of Community Health Workers (CHWs) and their role in improving community health. Real-life examples and a significant amount of academic research indicate that the most effective way to address the social determinants of health (SDHs) is to empower and train local community members such as CHWs. These workers are then deployed by community-based organizations (CBOs) to provide information, educate people about healthy living, and improve access to care. Investing in What Works in America, an entity developed by such organizations at the Robert Wood Johnson Foundation, which created a special edition in Health Affairs on community development and health, places CHWs as one of the workforces to be developed to improve community health. In an Investing in What Works conference in Boston on Nov 8th many emphasized the need for leadership to originate from the community where the purpose and goals for development can best be developed. This is exactly what a community based community health workforce would do.

However, we were surprised to see the CHW workforce described being unclear as not having a recognized definition and profession and the need to require credentialing and licensure. First in terms of a definition, the CHW section of the APHA, which is the largest national group of CHWs and their allies, created a definition that is accepted by the APHA and used by the Federal Department of Labor in its description and course requirements of the creation of CHW apprenticeship programs. That definition is as follows:

A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Secondly, a report on the count and employer demand for the CHW workforce in Rhode Island was completed by the Department of Labor and Training in 2009. Rhode Island is not only the first state to do a demand survey from an employers perspective but DLT was a regional finalized for the 2010 product/service award presented by Workforce Investment Council for this survey report.

Community Health Workers were recognized as a profession by the U.S. Department of Labor (DOL) in January of 2009 after a national campaign with over 1000 letters sent to DOL; marking the largest campaign request ever for a Standard Occupational Code (SOC). They were designated an apprenticable workforce by DOL in July 2010. Our state of Rhode Island's DLT recognized the CHW profession in February of 2012. However, we must not confuse this profession as yet another form of clinical medicine. Please note that several states have opted not to pursue licensing, such as New York, because CHWs are not a clinical occupation and there is minimal risk of harm from "unlicensed practitioners." A standards question may be valid and an acknowledgment that a payer for professional services has the expectation and the right to an agreement on the qualifications of a CHW and of those services. That being said, uniform standards or credentials can and should be defined by the practitioners themselves (the CHWs), and they do not have to resemble the licensing requirements of other professions. A strong case can be made that the process of developing and assessing the skills of this profession must be different from those of other health-related professions because the work is fundamentally different. There are clear guidelines and recommendations on the core skills needed from the landmark study on community health worker in 1998 by Rosenthal, L and Wiggins, N, as well as, the DOL work process for the profession published in July of 2010.

Lastly, while CHI-RI is dedicated to the creation of Community Health Worker Teams, we encourage the development of CHWs as patient navigators too. In that role/function, they should not be restricted to remaining physically located in the clinical facility - the greatest value to all concerned is when they have the latitude to work with people wherever they are. CHWs in the clinical setting communicates that the healthcare institution is sensitive to concerns of the community. In addition, the CHWs can and must become agents of change WITHIN the clinical setting. If they are truly CHWs they can help to humanize the system, and indeed in at least one example we know, they actually LEAD the patient care team. In all we do, we should be advocating for employers to "let CHWs be CHWs"

To end, it is quite inspiring to see Rhode Island move forward as a state that puts attention to the social determinates of health and recognizes the need to build leadership within the community to improve the health of the RI community at large. Thank you for this opportunity to review the State Health Care Innovation Plan and we hope you take our comments under advisement.

Sincerely,

Dannie Ritchie, MD, MPH
Clinical Assistant Professor Family Medicine
Lead, Transcultural Community Health Initiative
Brown University Center for Primary Care and Prevention
Founder, Community Health Innovations of Rhode Island
401 729 2065
dannie_ritchie@brown.edu

Dan Meuse <dmeuse@ltgov.state.ri.us>

Public Comments

Beth Lamarre <chwassociationri@gmail.com> Tue, Nov 26, 2013 at 4:06 PM
To: "shipcomments@ltgov.state.ri.us" <shipcomments@ltgov.state.ri.us>

November 25, 2013

I am writing in response to your call for public comments on the RI State Healthcare Innovation Plan. I am the Manager/Director of the Community Health Worker Association of Rhode Island (CHWARI), a trade association for the CHW workforce. CHWARI provides certification training, professional development, networking opportunities and other services for the state's CHWs.
CHWARI and CHW stakeholders are very pleased to see the inclusion of Community Health Workers in the State Healthcare Innovation Plan (SHIP), and hope to see an increase in the use of CHWs in efforts for healthcare outreach and impact on social determinants of health.
Community Health Workers have been an integral part of the healthcare workforce in RI and across the country for decades, and the positive impact they have had is becoming more and widely known.

In the SHIP, on page 34, it is mentioned that "Community Health Workers are under-recognized", and more specifically, that the "definition of Community Health Worker remains unclear". While it may not be well known throughout the healthcare and social service industries, there is a nationally accepted definition of Community Health Worker provided by the American Public Health Association's CHW section. A Community Health Worker is defined as "is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery." Moreover, there is an unclear understanding by the general public of the role and responsibilities of CHWs. However, there are nationally accepted standards, created by the CHW National Education Collaborative, that dictate the core competencies required of all Community Health Workers. In Rhode Island, these national core competencies are the foundation for CHWARI's CHW certification program.

When considering the final details of the SHIP, I would recommend that these nationally accepted definitions, core competencies and related curricula are considered and integrated. Using these references and CHWARI as a resource, all health care and social service professionals can be educated about the vital role of CHWs.

Please contact me with any questions or for more information on the CHW workforce.

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Beth Lamarre
Manager, Community Health Worker Association of Rhode Island (CHWARI)
www.CHWAssociationRI.org

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Manager, Community Health Worker Association of Rhode Island (CHWARI)
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Opioid Treatment Association of Rhode Island (OTARI)

Addiction Recovery Institute • Center for Treatment and Recovery • CODAC
Discovery House • Providence Metro • The Journey

November 26, 2013

Office of the Lt. Governor
State House : Room 116
Providence, RI 02903
Attn: Public Comments

Dear Lt. Governor Roberts:

Thank you for the opportunity to provide comment on Rhode Island's State Healthcare Innovation Plan.

It has been widely known that mental health and substance use disorders are costly in all sectors of society. Rhode Island is no different. It is also known that timely, focused and effective treatment can, and does, result in decreased healthcare costs. Indicated and appropriate treatment and recovery efforts also create healthier families and communities, greater productivity, reduced criminal behavior and, over all, have been demonstrated to produce value in excess greater than their cost.

The members of OTARI include every Opioid Treatment Program (OTP) licensed and accredited by the Substance Abuse and Mental Health Services Administration (SAMHSA), Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), and the Commission on the Accreditation of Rehabilitation Facilities (CARF). The members are also licensed by Rhode Island's Department of Health and registered and authorized by the US Drug Enforcement Administration (DEA).

Currently, OTARI members serve over 3500 patients, diagnosed with opioid dependence, who receive methadone as part of an evidence-based comprehensive treatment and recovery plan. Not included, but in addition to those served by OTARI, is a cohort of patients receiving other forms of opioid treatment (Suboxone®) or Vivitrol® in private, or other practice settings.

The members of OTARI (collectively) have provided treatment, recovery, prevention and education services to Rhode Island's citizens since 1971 and, along with other providers has a great interest and stake in how these services will be provided in the future. Additionally, we have a great interest and stake in assuring that care is delivered in a manner that maintains and improves upon identified best practice and is provided by individuals and entities possessing the skills to do so.

Rhode Island has had a long and successful history of supporting and partnering with community-based providers to serve the evolving needs and unique characteristics of these populations.

While the Full Committee, as listed, represents a broad constituency, we are puzzled by the lack of any representation or participation from members of the community provider groups that most serve the addiction and substance use disorder populations. Likewise, there appears to be no representation from the Drug and Alcohol Treatment Association of Rhode Island (DATA-RI) which represents this field much like The Rhode Island Council of Community Mental Health Organizations (RICCMHO) represents the mental health centers.

c/o CODAC – 1052 Park Ave., Cranston, RI 02910 • 401-275-5039 • 401-942-3590 (F) • mrizzi@codacinc.org

With respect to the Committee - Is it possible that our "group" was not invited to participate? Is it possible that our "group" failed to respond to an earlier invitation? In either case, we believe the plan would be significantly enhanced and improved with the input of the provider group serving this particularly unique and challenging population. Rhode Island's opioid treatment programs should be included as contributing providers in the behavioral health care network, offering services they are uniquely trained to do.

I am pleased to note your "invitation" on Page 61, *"The State would welcome additional suggestions for strategies to address Rhode Island's significant behavioral health and substance abuse problems"*. I know that I, and I'm sure my colleagues both at OTARI and DATA-RI and other members of the addiction and substance use disorder network, would welcome the opportunity to provide insight, education, and suggestions designed to improve the plan.

I look forward to hearing from you regarding this opportunity.

Best wishes for the Holidays.

Sincerely,

Michael Rizzi, Chair
OTARI

c/o CODAC – 1052 Park Ave., Cranston, RI 02910 • 401-275-5039 • 401-942-3590 (F) • mrizzi@codacinc.org

November 26, 2013

Office of the Lt. Governor
State House : Room 116
Providence, RI 02903
Attn: Public Comments

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It has been widely known that mental health and substance use disorders are costly in all sectors of society. Rhode Island is no different. It is also known that timely, focused and effective treatment can, and does, result in decreased healthcare costs. Indicated and appropriate treatment and recovery efforts also create healthier families and communities, greater productivity, reduced criminal behavior and, over all, have been demonstrated to produce value in excess greater than their cost.

CODAC Behavioral Healthcare has provided treatment, recovery, prevention and education services to Rhode Island's citizens since 1971 and, along with other providers has a great interest and stake in how these services will be provided in the future. Additionally, we have a great interest and stake in assuring that care is delivered in a manner that maintains and improves upon identified best practice and is provided by individuals and entities possessing the skills to do so.

Currently, there are thousands of Rhode Islanders in treatment for addiction and other substance use disorders. In fact, there are over 3500 patients receiving Medication Assisted Treatment (MAT) for opioid dependence provided by Rhode Island's six (6) MAT, or methadone providers. This does not include those receiving other forms of opioid treatment (Suboxone®) or Vivitrol® in private, or other practice settings. Nor does it include those receiving treatment and recovery support for other drugs of abuse.

Rhode Island has had a long and successful history of supporting and partnering with community-based providers to serve the evolving needs and unique characteristics of these populations.

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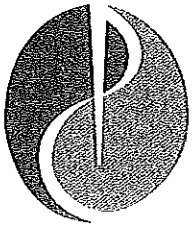
Best wishes for the Holidays.

Sincerely,

Michael Rizzi
President/CEO



The
Providence
Center

November 26, 2013

Mental health
and substance
use care and
treatment services
for adults, children,
adolescents
and families

The Honorable Elizabeth Roberts
Lieutenant Governor
State House
Room 116
Providence, RI 02903

Attn.: Public Comments

Dear Lieutenant Governor Roberts:

Thank you for the opportunity to offer comments and suggestions concerning the most recent draft of the State Healthcare Innovation Plan. Before I outline the suggestions my colleagues at The Providence Center and I have to offer, I'd like you to know how much we appreciate the transparency and inclusiveness that have characterized the process of developing this plan. It takes a lot of time and energy to ensure that as many citizens as possible have their say on the important issues this plan covers. You and your staff are to be commended for your commitment to hear every voice.

I'd also like to underline a theme that runs throughout the draft plan. As the CEO of the state's largest community mental health organization, I would like to reinforce an important concept that runs through many of the plan's recommendations – that is, that Rhode Island needs a more efficient, integrated health care system that includes a wide variety of behavioral health services if we are to make any progress in meeting the unmet health needs of our citizens and to begin to build a more efficient healthcare system. You will notice that I did not say that we need to invest more resources in the behavioral health system. For too long, that system has operated separately from the rest of the healthcare world. We believe strongly that new approaches that integrate behavioral health with the rest of the healthcare system will help our state address some of its highest cost, lowest value healthcare problems.

This integration is no simple matter. It is far more than simply co-locating behavioral health and primary care services. Making what have been conceptualized as two separate systems work together will take detailed planning and support from state agencies and the Care Transformation and Innovation Center contemplated in the draft plan. In The Providence Center's experience, models for integration are very different depending on the level of acuity of an individual's behavioral health concerns. We would look forward to working with a wide variety of constituencies to build on our successful experience with integrated services.

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www.providencecenter.org

Further, we applaud the draft plan's "one size doesn't fit all" approach. We do believe that models and approaches must be different depending on the severity of an individual's condition. We would note however that people move in and out of these risk categories. This is especially true of many behavioral health conditions as they are often recurrent, chronic illnesses. In developing integrated, enriched services, we must develop ways to ensure that supports can follow the person as his or her risk category changes.

We would also like to very strongly support the plan's inclusion of recovery support services as a way to address the needs of those affected by substance abuse disorders. Our work over the last several years with recovery supports and recovery coaching, largely conducted through our Anchor Recovery Community Centers program, is some of The Providence Center's most transformative work. Recovery supports are built around the assumption that the vast majority of those affected by addictions can and will recover. Rhode Island would benefit greatly from a better developed, better supported system of recovery supports.

We would like to express our support for the inclusion of behavioral health specialist staff and recovery coaches on community health teams as described in the draft plan. We especially would like to express our support for the recognition of the unique expertise of recovery coaches, either as part of these teams or as part of a larger system of recovery support services. We believe that provision of recovery supports can dramatically reduce the need for repeat substance abuse treatment. The overlapping effects of substance abuse and mental illnesses are a major factor in our state's pattern of high-cost care.

Regarding the plan's recommendations concerning CurrentCare, we believe this system is critical to ensuring a free flow of information bearing on patients' care. In addition to the recommendations in the draft plan, we would also like to urge development of a means for electronic health record systems to automatically check a patient's enrollment in CurrentCare. In our work to encourage our clients' participation, perhaps because of the continuing stigma surrounding receiving behavioral health services, our clients are reluctant to enroll, where they seem to enroll more freely in their primary care setting. Strengthening CurrentCare's ability to work across the whole system and addressing gaps that prevent healthcare providers from accessing full prescription records for clients no matter where they fill or pay for prescriptions would be significant improvements.

As the state plan looks toward facilitating the development of programs such as the Community-based Care Transitions program and the Advanced Payment Accountable Care Organization Program, we would urge an expansion of these programs focus beyond single disease states. For example, a patient with COPD's post-hospital discharge experience and outcomes will be significantly improved if a program screens and treats that patient's underlying depression. When these programs focus on outcomes limited to a single disease or condition, often these underlying issues are not addressed.

We would like to recommend that the draft state plan develop ways to connect with the state's roll-out of its duals initiative, particularly the second phase of the rollout which is scheduled in 2014 to incorporate dual eligibles with serious mental illness. The duals program can be an important source of support for the new programming this plan envisions, but only if the new kinds of services to be developed are made a covered service.

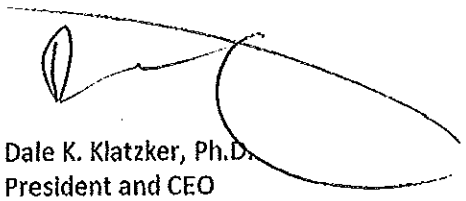
We appreciate the plan's emphasis on deeper engagement of patients. Because stigma and low expectations for improvement are so much attached to patients affected by mental illnesses and substance abuse disorders, we urge that these strategies promote recovery as a goal. We have adopted as an organizational expectation that the vast majority of individuals will recover when provided with the right services and support at the right time. We would urge that the plan develop this same idea as a way to deepen the engagement of individuals with mental illness and substance use disorders.

Regarding the plan's proposal to facilitate the development of primary care-led ACOs, we would like to point out that for many of those whose primary diagnosis is either a serious and persistent mental illness or a substance use disorder, they may be better served in a behavioral healthcare-led specialty ACO. The development of this kind of new model would need to be supported by resources provided by dedicated financing. There are a limited number of groups that have the capacity to take on the financial risk inherent in an ACO model. The proposed Care Transformation and Innovation Center could potentially develop ways to "backstop" performance risk at least for a transitional period.

We also strongly support the development of the sobering center mentioned in the draft plan. The Providence Center is one of several groups interested in collaborating on a Providence-focused pilot. Efforts should be made to evaluate and learn from this pilot to inform the development of other efforts.

Once again, thank you for the work you and your staff have done to promote such a thorough exploration of how we can work together to improve the health of all Rhode Islanders.

Sincerely,



Dale K. Klatzker, Ph.D.
President and CEO

Neighborhood Health Plan of Rhode Island

RE: Comments on Final Draft of Rhode Island State Health Care Innovation Plan

On behalf of Neighborhood Health Plan of Rhode Island we respectfully submit comments on Rhode Island's State Health Care Innovation Plan. We applaud the Lt. Governor and the State Innovation Model (SIM) Workgroups for their efforts behind this ambitious and wide-ranging plan. We offer the following comments for your consideration:

Innovations Grid (starting on Page 3)
Overall, the grid and the document would be strengthened with the addition of data to validate the many assumptions in the document.

- Include data to substantiate the health care challenges listed on the grid.
- Provide the references associated with the best practices listed under Innovation/Activity/ Intervention.
- Target performance – when possible include quantifiable objectives as a part of the outcomes measurement.

Prioritization
The document is broad and includes many laudable goals and ideas. However, the focus on accomplishing these goals could be improved by prioritizing a smaller number of initiatives and adding a calendar for sequencing when these efforts will be accomplished. To help with the prioritization we suggest:

1. Payment and Delivery Innovations and Tools
   - Focus on affordability by using the Affordability Standards set by the Office of the Health Insurance Commissioner's (OHIC). Similar standards are now required by Medicaid managed care as well. The progress made by the OHIC is important to build upon and to implement fully and successfully, which will likely encompass many of the initiatives listed in the Payment and Delivery section.
   - Develop state-based standards for EMR adoption with the goal of moving over time to a single, interoperable EMR platform across all providers. Rhode Island can capitalize on its geographic advantage and defined provider community to establish a single EMR that will yield true integration and remove fragmentation across health care delivery settings.
   - Create an Advisory Board for the Rhode Island Care Transformation and Innovation Center comprised of providers, all payers, consumers, businesses and academic institutions – Neighborhood would be pleased to fully participate on the Board.
   - Expand Community Health Teams (CHT) – we strongly encourage creating a CHT model that is flexible and allows for full alignment with primary care. As written in the draft SHIP, the CHTs sit outside of primary care and have the potential to create fragmentation when integration needs to be promoted. We would like to see CHTs embedded in PCMHs instead of establishing independent organizations as implied in the plan.

Neighborhood Health Plan of Rhode Island
299 Promenade Street • Providence, RI 02908 • Tel. 401-459-6000 • 1-800-963-1001 • Fax 401-459-6175

- Provider Directory – a unified provider directory is a significant undertaking and administratively burdensome task requiring ongoing maintenance. We recommend removing this from the list or making it a low priority.

2. Workforce Development
   - We recommend consideration of more specific goals in the area of promoting a strong primary care workforce. There should be more active involvement and alignment of the schools of higher learning in the state. CCRI, URI and Brown should provide ample opportunities to create the primary care workforce of the future. There have been discussions about URI developing a medical school. If the state plans to further explore forming a medical school based in URI, one guiding principle linked to funding is to make URI our state's main primary care training center.
   - We support the development of more primary care residency programs in PCMH sites. However, residency slots may be closely controlled by a national body and no institution is allowed to add positions. If this is the case, SIM can be an impetus in addressing this particular constraint.
   - We recommend that training of teamwork skills required to support and maintain PCMHs be included in the teaching curriculum for all providers (physicians, nurses, PAs, NPs, and BH providers).
   - We suggest shifting the focus of behavioral innovations from co-location to true integration of primary and behavioral health care. PCMHs should be managing routine behavioral health issues such as depression and anxiety using an integrated care team comprised of primary care, behavioral health and care coordinators.

3. Behavioral Health
   - We believe that one of the most urgently needed "innovation priorities" is forming a statewide coordinated multi-provider/stakeholder initiative to prevent and treat addictions to medications such as opiates/benzodiazepines. There are indications that substance use disorder is a significant source of morbidity and mortality in the state. These addictions add to the disease burden in the state and are a key cause of resource drain on many parts of the health care, mental health, social services, and correctional systems. Addictions can drive ED visits, hospitalizations, and inappropriate use of a range of health care resources.

4. Patient Engagement
   - Consider developing a goal specific to stimulate health care consumer engagement. RI has the potential to dramatically change the way health care is delivered and the manner consumers receive care as well as managing their own health. Specifically, the plan should call for the creation of a consumer assistance group charged with the implementation across the health care delivery system of best practices to further health literacy, informed decision-making and patient empowerment. RI has the opportunity to help transform health care consumers into savvy and informed purchasers of services, a critical step to ensuring overall innovation.

5. Population Health/Health Disparity/Social Determinants of Health Innovations

   - We strongly encourage a requirement to collect race and ethnicity data in all sectors of RI's health care system: state employees, Medicaid, HSRI, employers/commercial insurance. Currently, the availability and quality of this information is poor, making it difficult to create actionable interventions to improve the quality of care and service for racial and ethnic minorities.

We appreciate the opportunity to review and comment on the draft Innovation Plan and look forward to being a part of the ongoing collaboration to improve our health care system.

Sincerely,

Beth Ann Marootian, MPH
Director, Business Development

Peter M. Oppenheimer, Ph.D.
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November 26, 2013

Daniel Meuse
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State House Room 116
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ATTN: Public Comments
shipcomments@ltgov.state.ri.us

Comments on the State Innovation Health Plan Proposal
from the
Rhode Island Psychological Association
and the
Coalition of Mental Health Professionals of Rhode Island

Dear Mr. Meuse:

I am writing to provide comments on the State Health Care Innovation Plan Proposal on behalf of the Rhode Island Psychological Association and the Coalition of Mental Health Professionals of Rhode Island.

I would like to thank Lieutenant Governor Roberts, your staff and you for the extensive and diligent work you have put into developing this proposal. We also appreciate the time and effort that everyone who is participating in this process is giving. Transforming Rhode Island's health care services to address the "triple aim" of accessible quality care at lower costs is truly daunting. We hope everyone respects how important this process is for the future of Rhode Island and all Rhode Islanders.

It is essential that we recognize that this proposal does not address all the details and nuances that need to be articulated to successfully implement the concepts proposed in the plan. We hope that everyone reading this recognizes and accepts that everything in this plan requires refinement and assessment before it can be functionally implemented.

There are a number of major issues we would like to address:

1. We have a number of concerns regarding how the behavioral health, mental health and substance abuse needs of consumers can best be met.

At any time 25-28% of people have a diagnosable mental illness (including substance abuse).[i] Yet, most people with mental illness and substance abuse problems don't get help.[ii] Most of the people who get help get it from their primary care doctors, but that is not always the best way to serve them, in part because primary care doctors do not have specialized mental health training. We are looking for ways to bring the science of behavior change to healthcare to help people develop and maintain healthier lifestyles and to help those with physical illness, mental illness and substance abuse problems address their problems more effectively. We also recognize that the cost of health problems to employers is estimated to be three times as great for lost productivity, absenteeism and turnover than the cost of treatment itself.[iii]

There is ample research showing that providing appropriate mental health care can reduce patients' medical costs and that integrating behavioral health care with medical care also reduces costs, while improving quality. Chiles, Lambert and Hatch (2006)[iv] reported an average of 20% savings from implementing psychological interventions. Crane et al (2008)[v] reported reductions in services from 38% to 78% for "high utilizers." The American Hospital Association (2012)[vi], Melek (2012)[vii], Loeppke (2007)[viii] and Knapp (2013)[ix], provide summaries and reviews of the cost savings potential of coordinating mental health services and primary care.

We recognize that studies are showing that the prevalence of mental illness in Rhode Island his higher than in other states.[x] The incidence of suicide attempts is higher than the national average while the rate of successful suicides is lower than in other states[xi]. It also appears that more Rhode Islanders get treatment than do people in other parts of the county. Yet there are also estimates that more people are hospitalized for mental health reasons than is necessary and that some people are getting their mental health care thorough emergency departments because they lack access to other entry points of entry for care. Thus while it is good that more people are able to access care in Rhode Island than elsewhere, not everyone is getting access to the care they need nor are they necessarily getting the most appropriate care.

Throughout the literature on integrated and collaborative care, patient behavior and their mental health and substance abuse issues are recognized to be significant factors in their ability to access and participate in care. There is a "Rising Risk" population that has one or two chronic conditions. It is important to recognize that many patients with mental health issues also have physical co-morbidities. Expanding the opportunities for patients in this category to receive health and behavior services could be the difference between whether they remain at this level or rise to the high risk category (and thus

become even more expensive to treat). Psychologists are the leaders in health and behavior assessment and intervention services.

While the plan recognizes the importance of behavioral health interventions and that there is a role for behavioral health clinicians in PCMHs, it is not clear what that role should be and how such a role will be filled. The co-locations strategies described on page 61 under the heading "Behavioral Health Innovations" are incomplete. They do not account for the wide range of needs of patients for behavioral health, mental health and substance abuse services. It is essential that the plan further clarify how these needs will be addressed with the PCMH structure. It is important to consider what services can be provided by the PCMH itself and what services will be need to be accessible elsewhere. PCMH's will encounter behavioral health needs from common low-level issues to severe mental illness and low frequency issues. It is important to recognize that no physician or behavioral health clinician in a PCMH will be capable of addressing all the needs that will present in the office. We are willing and eager to work with the State on the appropriate inclusion of behavioral health care in PCMHs.

There are several issues and barriers that we identify that need to be addressed to provide proper behavioral health, mental health and substance abuse services to consumers, and to enable behavioral health clinicians to make the transition to healthcare reform.

A. Stigma around and discrimination against people with behavioral health issues, mental illness and substance continues. We must work to reduce this stigma and promote the ability of people who suffer from these issues to obtain the help they need for them. We must work to ensure that the Mental Health Parity and Addiction Equity Act of 2008 is faithfully implemented throughout the state.

B. Behavioral health clinicians are not included in information technology funding. That is now creating a barrier in our ability to work with physicians and hospitals, and that undermines efforts to communicate and coordinate care. Behavioral health clinicians will experience barriers to participating in EMR, Current Care and other communication mechanisms. Senator Rob Portman has just introduced the Behavioral Health IT Coordination Act of 2013, S. 1685, it would cover clinical psychologists in public and private psychiatric hospitals, community mental health centers, and residential or outpatient mental health or substance abuse treatment facilities. It would be helpful for Healthy Rhode Island to support this bill. If a federal solution is not promptly forthcoming the Rhode Island Care Transformation and Innovation Center (RICTIC) could provide funding and technical support to Rhode Island's psychologists and other professionals who are excluded from HITECH.

C. The current CPT codes are not transforming with the goals of healthcare reform. The codes do not account for the communications and quality assessment activities in which behavioral clinicians will need to engage to participate in coordinating and assessing the efficacy of their care. For instance there are no codes that account for the time clinicians spend communicating with other healthcare professionals either in direct communications or via the exchange of secure communications (nor for the infrastructure costs of this as well). We are also not included in codes that provide for transitional care management services. However, these services are currently captured by CPT codes that are considered evaluation and management services; as such most third party payers will not reimburse psychologists for these services. It would be helpful for the SHIP to encourage and support the development of strategies to reimburse professionals for services that are needed to make healthcare reform work but that are not included in the current procedure codes. The work that psychologists do in providing care coordination and transitional care management services for their patients must be recognized and reimbursed appropriately.

D. Psychologists are excluded from the Medicare definition of Physician. Including psychologists in the definition would allow psychologists to be treated like all other non-physician providers already included in the Medicare physician definition, thereby ending unnecessary physician supervision without increasing Medicare costs. There is a bill on Congress to that effect now. (H.R. 794 sponsored by Sen. Sherrod Brown and Rep. Jan Schakowsky). It would be helpful for HeathlyRI to support this legislation.

E. The ownership and decision making structures of PCMHs and ACO-like organizations are unclear. It is important that rules ensure that the needs of patients are addressed and respected. It is also important rules protect the professional integrity and independence of all professions providing service in the system. The "Medical Neighborhood" concept must be designed and utilized in a way that allows behavioral healthcare professionals to practice independently and collaborate with other healthcare professionals.

F. There are barriers to health service providers coordinating and collaborating in business arrangements that may interfere with the achievement of the triple aim. We have already alleviated one such barrier: we have revised the Professional Service Corporations statue (RIGL7-5.1-2 and 7-5.1) to allow professional service entities to be owned by wider range of healthcare professions. However, the federal antitrust laws may continue to serve as a barrier to some efforts to collaborate and cooperate without the forming large corporate entities that might create to a more competitive business environment in healthcare. These barriers should be monitored and addressed if it is the interest of the people of Rhode Island to do so.

G. It is essential that in planning the transition to coordinated care that we consider what services and policies will lead to the desired outcomes of a healthier and more productive community who has access to quality care and appropriate costs. That will require redistribution of resources. While some services will be appropriately curtailed or reduced, some should be enhanced and expanded. It is clear to us that to achieve the population health goals of healthcare reform that behavioral health, mental health and substance abuse services should actually be expanded and enhanced, and that this investment will lead to reductions in medical costs, and a healthier and more productive populace. For a generation Rhode Island has lacked/has had a great shortage of intermediate level services for mental health, behavioral health and substance abuse. Healthcare reform provides an opportunity to assess the entire system and to redirect resources where they will be most beneficial.

2. In the effort to use "accountable payment models based on the concepts of Accountable Care Organizations ("ACO") (pg. 38) we are concerned that caution be used to ensure that there remain opportunities for a diverse and competitive marketplace for healthcare services. We are very concerned that this approach could lead to the conglomeration of healthcare services under the banners of very few service providing entities. If that happens diversity and innovation could suffer, and the oligopoly that results would undermine future efforts to provide accessible quality services at appropriate costs. We are concerned that we are at risk for problems similar to what we have experienced with the limited number of health insurance companies over the past 20 years where we do not have enough competition from the vendors to enable the competitive environment.

We would like the proposal to enable and encourage less centralized entities to participate in providing coordinated healthcare services in a collaborative fashion without having to form unified corporate structures, and to ensure that new services providers have a way to enter the market. The state can help smaller entities to address barriers to such collaborations.

3. The plan relies heavily on the assumption that the current funding mechanism of fee-for-service-payments does not encourage efficiency in spending, and that such efficiency can be addressed by transferring risk to health service providers. It is important that we fully consider the implications of transferring control of financial resources and risk to service providers. It is important that plans be structured in ways that incentivize behaviors that are desired, and that do not crate unintended consequences or inappropriate secondary gains. We must recognize that if this plan is implemented along the proposed structure that while nearly all healthcare service providers and funding sources are well-meaning and honest, not all are and that some will take advantage of whatever there is to be taken advantage of just as they have done

in the fee-for-service system. Control of financial resources and the assumption of risk created these dynamics in the insurance, banking and investment industries, and it is at risk to occur in healthcare.

4. The plan focuses entirely on one financial strategy: "Rhode Island is committed to supporting the transition from the current fee for service health care environment to a system in which providers are accountable for the health of the attributed patient population. The state will encourage payment models supported by CMS including pay for performance, bundled payments, and shared savings programs as steps to reach full shared financial responsibility" (pg 38). The plan accepts the assumptions that there will be a multi-payer system and CMS assumption that it is desirable to pass risk to providers. The private insurance companies usurp significant amounts of the money spent by purchasers (government and private) for administration and profit. The Affordable Care Act has set a basic limit on how much they can take for their own purposes. The plan does not address how funding sources could achieve greater efficiencies and reduce their costs. The plan does not address the way medical equipment and pharmaceuticals are purchased. Equipment and pharmaceuticals are much more expensive in the United States than they are elsewhere, and there is no mechanism for determining appropriate prices for them as there is for medical services. The plan also not address where funds are expended in wasteful or other ineffective ways.

5. It is important to recognize that the small business and self-purchase insurance policies being offered by HealthSourceRI are largely high deductible high co-pay policies. Mental health professionals know that these plans create significant barriers to engaging and participating in assessment and treatment for many people covered by these plans. Some consumers will decline to come for services recognizing they cannot pay the amounts for the deductible and co-pay. Some consumers have accurately calculated that they could participate in weekly mental health treatment through their policy year and never meet their deductible. As such they effectively have no mental health benefit at all. Likewise, high copays also lead people to avoid participating in treatment.

Health plan benefit rules can create even more barriers. Sometimes plans do not allow patients to be seen for multiple services by different providers on the same day (i.e. they could not see their psychiatrist for their psychopharmacology and their psychotherapist on the same day.) Some plans require their insured to pay multiple copays even when the patient is seen by their primary care physician and the on-site behavioral health clinician in the PCMH the same day. We ask that the plan address and remedy these issues.

6. We have concerns that the goals of achieving population health objectives while preserving patient choice may not be entirely compatible. The best opportunity to achieve this would to appear to be if the system is comprehensively inclusive of all consumers, service providers and funding sources as occurs in many countries with national health plans. We recognize that most consumers indicate that they want to preserve their ability to choose their healthcare providers. It is reasonable to view this as part of a consumer's responsibility for their own healthcare. Most people would have difficulty comprehending how if they are told on one hand that they are responsible for their healthcare choices that they must follow the dictates of a plan or healthcare professional regarding where they get services, and the services they receive.

However at this time the insurance companies are in the process of developing and implementing more restrictive networks than Rhode Islanders have experienced in recent years. The merits of this tactic versus the merits of consumer choice are not being openly addressed in a manner that will help consumers to realistically understand the implications of the issue so that they can make informed decisions. Healthy Rhode Island needs to address this issue with the public at large.

7. It is important that state law and regulations be monitored and updated as necessary to address the changes in insurance and service delivery that are occurring. Beyond revising exiting laws and regulations, the implementation of Community Health Teams and case management will require that there be consideration of credentialing requirements (possibly a license) and legislation and regulation to define the Team members' scope of practice.

8. We are concerned that the actuarial data that has been presented in the recent meetings about the plan does not include sufficient information for the community to accurately assess and interpret that data. The full data, and Milliman's methodology needs to be shared promptly. The information presented is different from what we would have expected: that the rate of spending on mental health and substance abuse has been declining in proportion to overall health care spending[xii] and that it has stayed the same as fraction of Gross Domestic Product while overall health care costs have risen steeply[xiii].Government and private mental health and substance abuse reimbursement rates have not kept pace with the overall healthcare spending and the cost of living. In many cases they have declined while the costs of providing services continue to rise. Current reimbursement rates put the future of quality behavioral healthcare services in peril.

What is blatantly clear to us is that in light of all of the data showing how important behavior, mental health and substance abuse are towards the overall health of the population, and the healthcare costs that these issues create that not nearly enough resources are being allocated to address the behavioral, health, mental health ans

substance abuse needs of the community. A truly innovative healthcare system will allocate the resources necessary to address these issues and ensure that mental health and substance abuse are truly addressed with parity.

9. It is important that in the process of healthcare reform that information be provided to consumers that help them to understand and make informed judgments about their insurance coverage, lifestyle choices and medical care. This should include information that helps consumers understand the covered benefits, limitations and exclusions of their plans and how those factors impact upon their premiums, deductibles and copays.

10. The process of healthcare reform is truly complex. It is important that Healthy Rhode Island reach out to all stakeholder constituencies and make the process as inclusive and transparent as possible. We appreciate that the plan emphasizes the need to include all provider types, including behavioral health.

Thank you for considering our concerns. In our comments we have addressed a number of issues that will require ongoing exploration and discussion. We are eager to participate in this effort in the service of achieving the triple aim. The Rhode Island Psychological Association and the Coalition of Mental Health Professionals of Rhode Island look forward to continuing to work with you in this effort.

Sincerely,

Peter M Oppenheimer Ph.D

Peter M. Oppenheimer, Ph.D.
Clinical Psychologist

President-Elect
Rhode Island Psychological Association

Chair
Coalition of Mental Health
Professionals of Rhode Island

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Rhode Island Quality Institute

November 26, 2013

The Hon. Elizabeth Roberts
Lt. Governor, State of Rhode Island
State House Room 116
Providence, RI 02903
ATTN: Public Comments

Re: Draft State Healthcare Innovation Plan

Dear Lt. Governor Roberts:

On behalf of Rhode Island Quality Institute, I am pleased to submit comments on the draft State Healthcare Innovation Plan that was released for public comment on November 6, 2013. We applaud the efforts of your office to develop this roadmap for the state and believe that its creation represents an important step toward a transformed healthcare system that is coordinated, value-based, and sustainable. In particular, we strongly support the State's pursuit of the goal to transition at least 80% of covered lives into value-based care arrangements within 5 years and believe that this goal is the key driver for health system transformation. We recommend that the State prioritize this goal and the strategies needed to achieve this goal above all other items included in the plan. We also recommend that the State provide a clearer roadmap for how it intends to achieve the 80% goal. To make the State Healthcare Innovation Plan more actionable and to establish a path to success, we encourage the State to more explicitly connect the 80% goal to the strategies included in the plan, more specifically define the relevant strategies, and more clearly explain how the State will implement the strategies. In particular, we respectfully suggest the following changes to the SHIP:

1. Establish clearly defined goals and objectives for the Stakeholder Coalition that will develop accountable care strategies and structure, and provide regulatory or other authority to empower the convener to hold the coalition accountable to the goals and objectives. The work of the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) over the past five years demonstrates that a coalition-led initiative can achieve important and impressive outcomes, but in the absence of clearly defined goals and objectives, it may take substantial time for the coalition to achieve those outcomes and spread accountable care to a large proportion of the state's population. To achieve its goal to transition at least 80% of covered lives into value-based care arrangements, the State must take a more deliberate approach than would be observed under an organic process.

2. Adopt stronger language related to the use of value-based purchasing options by the State as a payer, and establish clearly defined goals for the proportion of State and municipal employees and Medicaid beneficiaries who will be in value-based arrangements. The State needs to demonstrate leadership in driving adoption of value-based purchasing and should take full advantage of its vast purchasing power toward achievement of the goal to have 80% of covered lives in value-based care arrangements.

3. Establish clearly defined goals and objectives for expansion of PCMH and ACO models to additional providers, invest in the infrastructure needed for continued expansion of the models, encourage local testing and refinement of the models, and promote the establishment of new PCMH and ACO initiatives. As demonstrated by CSI-RI, PCMH and ACO initiatives require substantial project management and infrastructure, particularly when they are executed on a large scale. The State should ensure that appropriate resources are available to effectively support these initiatives. It should also be recognized that, while many of us believe that the PCMH and ACO models improve care, there is limited evidence to support either model. Further testing and modification of the PCMH and ACO models may be necessary to achieve the Triple Aim, particularly for populations with special care needs, such as people with serious and persistent mental illness, home-bound elders, and people with developmental disabilities. In addition, the State should make a strong investment through the Rhode Island Transformation and Innovation Center or other entity to build and successfully execute a large-scale quality improvement infrastructure that can effectively help PCMH and ACO initiatives achieve their goals, potentially using Rhode Island's successful ICU Collaborative as a prototype.

4. Prioritize the creation of a centralized data aggregation entity, and align the aggregation entity with the Rhode Island Care Transformation and Innovation Center. Easy access to timely and reliable data and the ability to act on that data are both critical to the transformation to a value-based health system. At present, providers, payers, and other stakeholders have insufficient access to data to meet their needs, and they often struggle to use the data that is available to improve care. Addressing both of these challenges will be necessary for Rhode Island to successfully transform to new payment models.

5. Invest in incentive-based programs and use regulatory power (where appropriate) to achieve widespread adoption of health information technology (HIT). We believe that increased adoption of HIT is critical to the success of Rhode Island's efforts to promote value-based purchasing arrangements. Over the past 10 years, Rhode Island Quality Institute has worked with a broad base of partners to support adoption of HIT and encourage use of CurrentCare, but we believe a stronger approach that leverages both incentives and regulatory power will result in more rapid adoption of HIT and better position the state for successful transition to a value-based system.

Thank you for the opportunity to participate in the planning process and to review the draft plan. We appreciate your consideration of our comments. Please do not hesitate to contact me at ladams@riqi.org if you have any questions.

Sincerely yours,

Laura Adams
President & CEO

Dan Meuse <dmeuse@ltgov.state.ri.us>

Fwd: State Health Innovation Plan

Jason Rafferty <Jason_Rafferty@mail.harvard.edu> Tue, Nov 26, 2013 at 2:02 PM
To: shipcomments@ltgov.state.ri.us

Re: State Health Innovation Plan"

As a pediatrician and child psychiatrist, I am concerned that the draft State Health Innovation Plan's gives very limited attention to children, families, prevention, and public health. The most cost effective measures to reducing morbidity and promoting well being state-wide is to focus on children and social determinants of health. Disease, illness and injury always occurs within the context of one's family, neighborhood, and state politics. Social determinants including poverty, unequal access to preventative care, lack of education, stigma and racism play an important influential role in the equity and health of our citizens. Almost 35 % of urban high school students in RI drop out before graduation, which does not fare well for the future health of our state. Second, healthy development is also adversely influenced by young children's exposure to extremely stressful conditions, such as recurrent abuse, chronic neglect, caregiver mental illness or substance abuse, and/or violence or repeated conflict. Toxic stress, or prolonged activation of our internal stress response systems, can disrupt brain development increasing the risk for stress-related disease and cognitive impairment well into the adult years. However, research shows that, even under stressful conditions, supportive, responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response. Therefore, our state health plan needs to incorporate a stronger focus on expanding pediatric medical homes to all children, providing accessible and high quality mental health services to both children and their parents, and supporting our social systems (schools, early childhood education centers, neighborhoods and communities) to ultimately promote developmental and behavioral health.

Jason Rafferty, MD/MPH

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DATA
Drug and Alcohol Treatment
Association of Rhode Island
Representing Treatment and Prevention Providers

November 26, 2013

To whom it may concern,

The Drug and Alcohol Treatment Association of Rhode Island represents over 25 agencies which provide Substance Abuse and Behavioral Health treatment services in the state of Rhode Island.

In the process of a review of the draft of Rhode Island's State Healthcare Innovation Plan it has come to our attention that there was no mention made of the comprehensive SA treatment network that exists in this state.

On any given day 4,000-5,000 individuals are receiving SA treatment services. The majority of which is not provided at a mental health center.

The introduction mentions that the plan does provide a review of the current health care system. We feel that addiction treatment is in fact a significant part of the health care system and to omit this critical component renders this plan incomplete and inaccurate. Most of our member agencies are providing proven evidenced based treatment services with excellent patient outcomes.

In addition our concerns are the following:

- Although behavioral health is referenced throughout the document, it is unclear as to its definition. More often than not, community mental health centers are referenced and discussed; yet the substance abuse treatment network is not detailed or even mentioned. If behavioral health is included, it is not clearly articulated within the plan which leads the reader to make unsubstantiated assumptions.

-Substance abuse refers to a set of related conditions associated with the consumption of mind – and-behavior-altering substances that have negative behavioral and health outcomes. In addition to significant negative primary health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in addressing public health issues.

-As it is true with any mental-health diagnosis, there is no one test that definitively indicates that someone has chemical abuse or addiction. Therefore a comprehensive medical, family and mental health assessment must be completed by practitioners and individuals specifically educated and credentialed in the field of addictions. The community health teams as defined in the document make no mention of licensed or credentialed workers in the field of addictions. Also, while recovery coaches are mentioned, they are only one member of the multidisciplinary team required to support and meet the needs of the patient.

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- The document references an analysis conducted by Milliman revealing diagnosis information across all payers (Commercial, Medicaid and Medicare). This analysis does not include addictive disorders. To this end, it is important to also recognize that Rhode Island ranks 13th with the highest overdose mortality rate in the United States;

- In recent years, the impact of substance and alcohol abuse has been notable across several areas including adolescent abuse of prescription medications and Substance Abuse issues with military members, veterans and their families. In addition, as the federal government implements health care reform legislation, attention will focus on the provision of services for substance abuse and mental health illness, including new opportunities as a result of the new Parity regulations. Access to and coverage of addiction treatment and prevention services will undoubtedly increase.

- Rhode Island has nationally recognized experts in the field of Chemical Dependency and Addiction located at Brown University's Center for Alcohol and Addiction Studies, the University of Rhode Island and R.I College Department of Psychology. We also have Individuals involved with the following professional associations: American Academy of Addiction Psychiatry, American Society of Addiction Medicine and the International Nurses Society on Addictions. To our knowledge, no individuals from these organizations or groups were involved in the actual development of this document.

In Summary, we are requesting representation from the substance abuse provider community and the opportunity to provide input as referenced on page 61 of the plan. We are confident that with the inclusion of specific addiction disorder information, data and services the plan will more accurately reflect the current status of the behavioral healthcare field. It will also provide a healthier and more promising roadmap for the future for all Rhode Islanders.

Sincerely,

David Spencer, MBA, MPA
Executive Director
Drug and Alcohol Treatment Association of Rhode Island

235 Promenade Street | Suite 455
Telephone: 401-274-1771

RIHCA
RHODE ISLAND HEALTH CENTER ASSOCIATION

Providence, Rhode Island 02908
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November 26, 2013

Office of Lt. Governor
State House Room 116
Providence, RI 02903
ATTN: Public Comments

Dear Lt. Governor Roberts,

I am writing today on behalf of the Rhode Island Health Center Association (RIHCA) to thank you and your office for managing the Healthy Rhode Island initiative, and to offer comments on the draft State Healthcare Innovation Plan (SHIP). As you know, there are many exciting programs, projects and initiatives in Rhode Island that seek to improve the health of Rhode Islanders. Your leadership has been crucial to the statewide efforts to implement health reform in Rhode Island, and to move forward many important conversations regarding healthcare in Rhode Island.

RIHCA represents Rhode Island's nine community health centers, which include eight federally qualified health centers (FQHCs) and one island-based health center, with twenty-nine locations throughout the state. In addition, one community mental health organization, the Providence Center, is an associate member of RIHCA.

In Rhode Island, where there are no state or county operated health departments with primary care services, the community health centers serve as the de facto public health primary care delivery system for the state. Unfortunately, the language in the draft SHIP does not fully reflect the role of the community health centers in Rhode Island, and some of the data is outdated or incorrect. We hope that you will consider using some of the information provided here to describe the community health centers in the final draft of the SHIP.

In 2012, Rhode Island's FQHCs saw 134,905 patients; over 13% of Rhode Islanders get their primary medical, behavioral health and dental care at a community health center. Nearly half of FQHC patients are publicly insured (40% Medicaid; 7% Medicare); 32% of patients are uninsured and 19% of patients are privately insured. Complete 2012 data for Rhode Island's FQHCs, including center by center reports, can be found at http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&state=RI#glist.

Rhode Island's community health centers are on the forefront of innovations in the delivery of high quality primary medical, dental and behavioral health care. 100% of community health centers in Rhode Island have adopted electronic medical records. Seven FQHCs participate in CSI, and all eight are on the path to be recognized by NCQA as patient-centered medical homes by the end of 2014. Of the eight FQHCs, five are recognized by NCQA as level 3 patient centered medical

homes, and two more have applications pending; many of these FQHCs operate more than one location.

General comments

The SHIP properly notes that there are both many opportunities for change, as well as much innovation that is currently underway in the Rhode Island health delivery system. It is an ambitious description and plan, in a state where we are ambitious, and have a robust history of innovation. It appears that much of the plan is an inventory of our current healthcare system and system innovations currently being implemented or planned in the state. As we understand it, this iteration of the state health innovation plan is intended as an end product of the substantial planning process undertaken this past year. When the time to apply for future funding approaches, we understand that the state intends to seek funding to implement specific parts of this plan. That will be an important opportunity to further focus efforts to drive statewide innovation.

As the state moves to the next level in this planning, there is a clear need to become more focused. It is our hope that the state would take the opportunity to truly innovate around the integration of behavioral health and primary medical care. What follows are some brief over all comments on three areas of the SHIP which we hope will be further strengthened in future iterations or applications for funding.

Behavioral healthcare

It is our hope that future innovation efforts seek strategies to drive the integration of the behavioral healthcare and primary medical care systems. Integration, not co-location, is the key to success here. Co-location is a possible first step, but describes what is currently happening in some Rhode Island practices. Rhode Island is ready to take the next steps, to pool the already available resources in the delivery system, and figure out how to best distribute them in a highly functioning, integrated and patient-centered way. This may result in more than one model based on varied patient populations and needs.

The Role of Patients

The SHIP is a great opportunity to drive some truly patient-centered innovation. The state should take every opportunity possible to engage patients in designing and implementing innovations. The language in the draft SHIP could be strengthened by spending more time discussing patients as active participants in their health care, and could put the patients at the center of innovation and redesign of the health care system. Some of the discussion in the SHIP around "patient responsibility" seems that it might be focused on financial consequences if a patient does not follow provider recommendations for treatment. While financial incentives are one way to drive reform of systems all around, a truly patient-centered system would be developed around the needs of patients and involve

patients in the design. This seems to echo some of the conversation around patient "compliance" or "adherence" to prescribed medical treatments. *See, e.g.,* Dr. Danielle Ofri's blog entry in the *New York Times* "Well" blog, "When the Patient is Noncompliant," Nov. 15, 2012. Patients' lives are complicated, and decision making, treatment decisions, and indeed system design all need to take into account patient priorities, needs and values in order to put the patient at the center of the patient centered medical home. Further involvement of patients in the design and implementation will only strengthen the innovation we are able to accomplish.

Community Health Teams and Community Health Workers

Community health teams should be extensions of patient centered medical homes. The teams might and should have satellite locations and be developed in close collaboration with community organizations, but the connection to the primary care home must be strong. If these teams are organized outside the primary care home there is a risk that the connections will be difficult to establish and maintain. In addition, every primary care medical home has as part of its design certain members of its team that serve as health navigators, nurse care managers, health coaches or other types of links between the community and health care system. To situate community health teams outside the medical home would result in a redundant, parallel system of health navigators, care managers, and patient advocates. We should use resources to extend and complement current teams that already exist inside medical homes, and to help them establish and maintain strong ties with community organizations in their areas.

Community health workers are often valued members of patient centered medical home teams, and function as valued team members inside and outside the medical office. We should not require licensure for community health workers, and it is our fervent hope that suggestions to the contrary be removed from the SHIP. Community health workers serve as bridges between the healthcare system and the community. They do not provide health care. Job-specific training and experience requirements are best managed by employers, and do not require licensure. Additionally, licensure would impede the flexibility required for these teams to be successful even before community health teams have been fully defined or tested in Rhode Island.

Thank you once again for the opportunity to comment on the draft SHIP. We look forward to continuing to work with the state as we move forward on these and other innovations in Rhode Island's healthcare delivery system.

Sincerely,

Jane A. Hayward

Jane A. Hayward
President and CEO

Leslie N. Wood
Senior Director
State Advocacy

PhRMA

Governor Elizabeth Roberts
Office of Lt. Governor
State House Room 116
Providence, RI 02903
ATTN: Public Comments

Dear Governor Roberts,

The Pharmaceutical Research and Manufacturers of America ("PhRMA") is pleased to submit comments on the draft of Rhode Island's State Healthcare Innovation Plan. PhRMA is a voluntary nonprofit organization representing the country's leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives. PhRMA companies are leading the way in the search for cures.

As Rhode Island convenes a stakeholder coalition to develop accountable care strategies and structure, PhRMA encourages the State to consider the following recommendations that support patient access, quality improvement, and innovation:

- Rhode Island should support choice and competition among health plans and providers.
- As the State develops governance for ac countable care organizations (ACOs) and alternative payment models (APMs), the process should be guided by meaningful input from patients, practicing physicians, and other stakeholders with relevant clinical expertise. For example, APM development should be guided by input from physicians practicing in relevant treatment areas and specialties. To the extent possible, one or more patient representatives should also be involved in the development of APMs. In addition, ACO governance should include one or more patient representatives.
- The Rhode Island Care Transformation and Innovation Center (RICTIC) and stakeholder coalition should ensure robust quality measure sets for ACOs that include, where possible, measures of clinical outcomes – recognizing intermediate health outcomes, patient reported outcomes, quality-of-life, and functional status as types of health outcomes. ACOs' should demonstrate that financial incentives for cost containment are balanced by measures of health outcomes. Measures should be reassessed on a regular basis to identify new or remaining gaps and to ensure that measures are maintained to keep pace with changes in technology and clinical practice. In addition, ACOs and their Rhode Island payers should work to add quality measures for clinical conditions where financial incentives are not balanced by quality measures, including identifying endorsed measures that can fill gaps and developing new measures where currently endorsed measures do not exist.

Pharmaceutical Research and Manufacturers of America

950 F Street, NW, Suite 300, Washington, DC 20004 • Tel: 202-835-3451 • FAX: 202-715-6987
E-Mail: lwood@phrma.org

- Rhode Island should ensure that ACOs have incentives to manage the total cost of care on a system-wide basis, rather than silo the cost of various products and services. ACOs should demonstrate the ability to manage the cost of care and have in place the necessary Health information technology to do so.

- ACOs should promote delivery of treatments and services recognized as the standard of care, as described by tools such as clinical guidelines, compendia, and other elements of evidence-based medicine.

- ACOs and APMs should give physicians and patients flexibility in choice of treatment and services, and should preserve and respect informed, shared decision-making by patients and physicians among available treatment options in recognition of heterogeneity among patients. Patients should be given information to support choice of ACO including the ACO's network of providers and any cost-sharing differences between ACOs. Physicians should also give patients information needed for high quality shared decision-making, and patients should have access to a timely, transparent and affordable exception and appeals process.

- If ACOs conduct assessments of novel treatments, they should provide transparency and independent review. Pharmacy and Therapeutics committees involved in making assessments of new medicines or medical technologies should consist pri marily of practicing physicians and pharmacists, come from a range of specialties, meet regularly, make their assessment criteria clear, base clinical decisions on the strength of scientific evidence, standards of practice and treatment guidelines, and account for heterogeneity among patients.

- Rhode Island Medicaid should rigorously evaluate alternative payment models within two years of development

- ACOs should promote comprehensive medication management (CMM) as the standard of care. CMM should include assessing each patient's medications for appropriateness, effectiveness, safety, and ability to be taken as intended; developing a care plan that addresses any medication problems; follow-up evaluation of the patient to ensure outcomes are achieved; and communication with the patient's health care provider.

Thank you very much for the opportunity to comment on Rhode Island's draft Healthcare Innovation Plan. We look forward to the opportunity to work with the State as it convenes its stakeholder coalition to address accountable care strategies, and we respectfully ask that representatives from our industry are included in these discussions. Please contact me, if you have any questions regarding these comments.

Sincerely,

Leslie N. Wood

Dan Meuse <dmeuse@ltgov.state.ri.us>

Healthcare Innovation Plan Comments

Rhode Island ACLU <riaclu@riaclu.org> Tue, Nov 26, 2013 at 9:26 AM
To: shipcomments@ltgov.state.ri.us

Dear Lt. Governor Roberts:

At this time, the ACLU of RI would like to offer two comments on your office's draft Healthcare Innovation Plan.

1. On Page 58, the plan refers to potentially expanding the reach and use of the APCD. When Department of Health regulations were being proposed on the implementation of the APCD, the ACLU raised a number of privacy and confidentiality concerns and urged a number of amendments to the rules. While some changes were made, the ACLU still has a number of concerns about the database's inadequate protection of patient privacy. We believe that if any efforts are made to expand the use of the database, it is critical that privacy issues be reexamined and additional privacy safeguards be added, and that any plan recognize that need.

2. On Page 62, the draft plan supports requiring payers and employers to complete "Personal Health Risk Assessments" in order "to help residents understand and address their [health] risks." The ACLU believes that any attempt to mandate such assessments is unduly invasive and raises significant issues under state and federal anti-discrimination laws. We recognize the value of these assessments, but we do not believe their completion can be mandated without raising serious policy and legal concerns. We urge that this recommendation be eliminated.

Thank you for your attention to our views.

--
Steven Brown
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Join the ACLU: http://www.riaclu.org/GetInvolved/Join.html

COMMENTS FROM AARP RHODE ISLAND
By Deanna Casey, Associate Director, Advocacy
dcasey@aarp.org

SUBMITTED NOVEMBER 25, 2013

AARP recognizes that Rhode Island's plan is building on a system of managed care that it has been developing for a number of years. The SIM proposal builds on reforming an existing system that has been active for many years and it will rely on an expansion of what it is currently doing.

Rhode Island's plan has the potential to work well for consumers and deliver more coordinated, less costly care. Again, AARP congratulates the state for wanting to move in the right direction. However, the issues are always found in the details and it is still early to comment specifically on details that have not yet been well-developed. It's important to continue to stress some very important principles that Rhode Island should maintain awareness of as they continue the design of these programs.

The comments below are made at a high level and present some important themes in the continued development of the SIM proposal:

Consumer Involvement

It is vitally important that there be organized and respected consumer involvement in the design process and in the implementation phases of the SIM plan. The inclusion of an active consumer advisory council is a good first step but in addition, we recommend that there be strong and active consumer representation on most of the plan design committees.

Consumers should have access to active participation at all strategic meetings, not just at their own advisory committee. The question of how any design decisions will impact consumers should be an uppermost concern. AARP supports consumer involvement during the initial phases of plan implementation and on key advisory committees during the operational stages of the implementation.

Continuity of Care and Individualized Plan of Care

Whether or not the plans end up instituting voluntary enrollment, AARP believes it is vital that sufficient attention is directed to individuals who are transitioning into a new delivery system and/or to a new primary care physician/new providers. If enrollment in a plan results in a change of primary care physician, AARP urges a face-to-face assessment of the needs with the new participant. Telephonic engagement could work for a young, healthy population, but for individuals with more complex needs, health plans must get to know first-hand the needs of these individuals. If the state wants to achieve the goal of better care with lower costs, it is essential that plans and providers understand not only the health needs of plan participants, but also the functional and other adult daily living needs.

AARP believes that plans need to engage not only with their new members, but also with the support systems they have that can help achieve both individual and state plan goals. This means, at a minimum, an initial face-to-face engagement with the individual and support system in developing a plan of care for the health and well-being of the individual. This may not apply to all individuals, but it should become engrained as standard procedure for assessing need, developing a plan and ensuring involvement by stakeholders, such as family caregivers and others who can assist in implementing

the plan of care.

Monitoring Service Delivery and Care Transitions

AARP feels strongly that the plan, medical home, ACO or other entity have robust methods for monitoring the health and well-being of all program participants. We recommend the development of a determined plan on frequency of direct contact with the plan participant that should be included in any plan of care. Often health plans know of a member's hospitalization after it occurs. While one cannot prevent every acute care need, we encourage developing a care system with a built-in expectation that there is sufficient involvement with the plan participant for avoiding potential acute care occurrences. Additionally, if a plan participant is hospitalized, there must be clear accountability on what entity will be responsible for an effective transition back to the home or to a rehab facility. Care transitions need to be closely monitored and plans held accountable for ensuring the best outcome for the consumer. This is clearly one area that needs to be monitored, measured, rewarded or penalized for performance.

Data and Performance Benchmarks

Health plans and other coordinating entities are becoming increasingly familiar with increased demands for data on both financial and care benchmarks. AARP is very concerned that plans not be given financial incentives to withhold care which has been done for many years in many states. Data must be collected and benchmarks set to reward plans and other coordinating entities based on health outcomes for the consumers they serve. AARP opposes any payment system that monetarily rewards plans solely on a per member per month basis. That system inevitably leads to withholding care and/or denials of legitimate claims. AARP urges the use of best practices methodologies that reward plans for specific performance and to consider penalizing plans that do not meet accepted performance standards. This can be approached in different ways, but plans should understand that there are defined indicators that can reveal whether defined outcomes are being achieved.

To: Office of the Lt. Governor
State House Room 116
Providence, RI 02903
ATTN: Public Comments
(also emailed to shipcomments@ltgov.state.ri.us)

November 25, 2013

From: Al Kurose, M.D., FACP
President and CEO, Coastal Medical

Re: **Public Comment on the Draft State Health Innovation Plan**

Introduction

I applaud the collaborative process that Healthy Rhode Island has used to prepare the State Healthcare Innovation Plan (SHIP). Our small state is already a national leader in healthcare reform. Coastal Medical is at the forefront of many of the initiatives underway here. A successful State Innovation Model (SIM) application could be a powerful catalyst for healthcare delivery system transformation that would benefit all Rhode Islanders.

Leadership:

Leadership will be a key success factor in the effort to accomplish delivery system transformation and payment reform in Rhode Island. The call for a stakeholder coalition to develop accountable care strategies and structures is a move in the right direction. The successful experience of CSI-RI has demonstrated the value of bringing together payers, primary care practices, and employers with OHIC as convener. However, a successful accountable care coalition will need to address analytic, financial, and strategic complexities that go well beyond the challenge of Patient Centered Medical Home Practice transformation. The proposed accountable care coalition will therefore require more participation of stakeholders with knowledge and experience relevant to these complexities. This will mean bringing in more business leaders with specialized expertise from payer, provider, and employer organizations to work side by side with physician and administrative leaders already active in collaborative healthcare leadership across the state.

Stakeholders

Inclusion of all types of providers should be the ultimate goal of the accountable care coalition. However, I believe the work should begin first with primary care providers, hospitals, payers, and employers. In this manner, the coalition could design and implement foundational constructs without an overwhelming degree of complexity at the outset. The coalition could then add different types of providers in waves, perhaps bringing in behavioral health providers and medical subspecialists as logical choices for the next group of participants.

Core Competencies:

All stakeholders in the process of delivery system transformation and payment reform should acknowledge at the outset that competency in data collection and analysis with regard to clinical quality, patient experience, and cost performance is crucial. Payers and providers of all types

will have to invest in human resources and technology. Some aspects of data collection and analysis can be "centralized," but the identification of opportunity in such data, and the design and implementation of programs to improve care and reduce costs will be *unique challenges for each organization.* Acquiring core competency in advanced data collection and analytics will be a "heavy lift" for payers and providers alike. We should acknowledge this up front.

Statewide Data Aggregation and Analytic Tools

There is an opportunity for state government to support and drive delivery system transformation and payment reform through centralized reporting of clinical and financial data. However, I believe the SHIP needs more clarity of focus about what this really means. Physician practices, hospitals, and other providers engaged in accountable care will need detailed total cost of care reports and utilization reports based on claims data by payer in as close to real time as possible. The provision of such reporting in real time has not been part of past descriptions of the goals for the APCD. Provider entities will also need clinical quality reports derived by analysis of a composite of claims-based and EMR-generated data about both test results and services rendered to patients. This type of reporting will require highly complex interactions amongst the reporting entity, each payer, and a diverse spectrum of providers all with differing health IT sophistication and using different EMR's. Coastal's experience to date in developing these capabilities internally suggests that a large investment of time and money will be required to accomplish these competencies at a system level.

Aggregation of Providers To Assess Performance and Calculate Payment

The SHIP does not address in detail the reasons that providers need to aggregate into groups to execute accountable care, nor does it speak to some of the challenges inherent in implementing such aggregation. Issues relevant to aggregation of providers include:

- Performance measurement re: clinical quality, patient experience, and cost performance require large "sample sizes" of patients to be statistically valid.
- Since cost performance in accountable care is likely to be measured and paid for by each payer separately, it becomes even more difficult to aggregate a sufficient number of providers to create a single-payer population of patients that is large enough to make meaningful assessments of cost performance. Most experts estimate that a population of at least 5,000 (and preferably 10,000) patients is needed to implement accountable care. With 88 physicians, Coastal has an "original" Medicare population of about 10,000 patients. These figures convey a sense of the number of physicians one needs to create a single-payer population of sufficient size to implement accountable care.
- Aggregated providers must agree to "sink or swim together" regarding their performance on clinical quality, patient experience, and cost. For such a construct to make any sense, these aggregated providers need shared mechanisms for measurement and reporting, care coordination, quality improvement, and implementation of new clinical initiatives.
- Even with centralized reporting from the state, providers will still need a significant shared infrastructure to transform care and succeed under performance based payment models.

Conclusion

Significant leadership, consultative expertise, IT support, working capital, and performance incentives will be minimum requirements to drive the aggregation of providers and the creation of infrastructure needed to implement accountable care across Rhode Island. The Rhode Island Transformation and Innovation Center could potentially meet many of these needs.

The notion of seeking out expertise in transforming the healthcare delivery system of an entire state is somewhat problematic, because there is no clear precedent for meeting this challenge and there is no such expertise for us to call upon. In Coastal's work to transform healthcare delivery and payment models, we have taken advantage of collaborative opportunities wherever we can find them, we have studied the best practices of others and taken away pieces that work for us, and we have shared best practices internally across our offices. At times, we have also simply experimented with change based on our own intuition and experience, and worked by trial and error to figure out how best to serve our patients. Perhaps similar processes might be useful in execution of the SHIP.

A successful SIM application could bring a once-in-a-generation opportunity to transform healthcare in Rhode Island. Coastal is eager to assist finalization of the SHIP in any way possible.

Respectfully submitted,
Al Kurose
11/25/13

Hasbro Children's Hospital

The Pediatric Division of Rhode Island Hospital

A Lifespan Partner

General Pediatrics &
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Adam D. Pallant, MD, PhD

Randal M. Rockney, MD

Delma-Jean Watts, MD

The Honorable Elizabeth Roberts
Lieutenant Governor of Rhode Island
82 Smith Street
Providence, RI 02903-1105

Dear Ms. Roberts:

It is with great concern that I write about the SHIP draft.

The most glaring omission is the sparse discussion of children. It is astounding that the document would neglect nearly 25% of Rhode Island's population. Children have specific needs regarding health that differ greatly from adults and are not "little adults" with little needs. Investment in children's health has shown to have the most return.

My second concern and more specific is directed at Community Health Workers, page 34, item 12:

Despite the successful program at the Rhode Island Department of Health, in the marketplace that is considering new forms of value-based care, the definition of "Community Health Worker" remains unclear. Furthermore, awareness of the existence of this specialty and function is low among providers.

This is not entirely true. There are certainly core agreed upon characteristics of Community Health Workers (CHW). I see the benefits of CHW as director of Hasbro Children's Hospital Refugee Health Program and also Fostering Health Program (children in foster care) of CHW. Is it cheaper to have CHW instruct these families in a linguistically and culturally appropriate manner or have the children end up in the emergency room? Both refugees and foster children are populations that have very specific and potentially "expensive" health needs and difficulty accessing health care. In fact, in one study involving 50% of our refugee CHW we documented over 800 encounters on behalf of patients over 1 year that involved access to health care and preventative services/education by CHW. These were all uncompensated calls. Those of us who work with high –risk, medically costly populations are very much aware of the value-based care the CHW provide. Currently, they perform their services without compensation, which is not only unfair, it is not sustainable.

Thank you for considering more focus on health needs of our state's children and reconsidering your statement on CHW.

Sincerely,

Carol Lewis, MD
Director Refugee Health Program
Fostering Health Program
Hasbro Children's Hospital Primary Care
Associate Professor of Pediatrics (Clinical)
Alpert Medical School of Brown University

THE
UNIVERSITY
OF RHODE ISLAND
COLLEGE OF
NURSING

THINK BIG WE DO℠

November 24, 2013

Office of the Lt. Governor
State House Rm 116

Providence, RI 02903

ATTN: Public Comments

Dear Lt. Governor Roberts:

Thank you for the opportunity to comment on the RI State Healthcare Innovation Plan. As a practicing nurse practitioner and professor, I take the role and the value of the nurse practitioner very seriously, as I know you do. At present, RI still has significant barriers to practice, primarily through the credentialing policies of the third party payers in RI. Allowing NP's to work to their full practice authority will greatly increase the access to care to the 56,000 presently medically uninsured citizens, who will be newly credentialed through the RI Health Exchange.

Please find attached my comments to the Healthcare Innovation Plan document. I appreciate your continued support of nurse practitioner practice and look forward to assisting you and your staff in putting forth a plan that will insure better access to cost-effective health care for individuals and for populations in Rhode Island.

Please feel free to contact me with any questions or for further comment.

Sincerely,

Denise Coppa

Denise Coppa, PhD, RNP
Coordinator
Family Nurse Practitioner Program
President
Nurse Practitioner Alliance of RI
dcoppa@mail.uri.edu

NURSE PRACTITIONER ALLIANCE OF RHODE ISLAND
224 Cole Dr.
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RI'S STATE HEALTHCARE INNOVATION PLAN
COMMENTS

The Nurse Practitioner Alliance of RI (NPARI) applauds the three aims of the innovation plan as proposed in the Lt. Governor's November 6, 2013 draft. As the professional representative group for the **819 licensed nurse practitioners** (NPs) in RI, NPARI agrees that: providing better health care for individuals and populations while reducing per capita costs can serve as a model for changing the health care system in RI in a positive, more accountable and organized way. It is well documented that NP's have demonstrated consistently delivered cost-effective, high quality care in the United States since 1965 (AANP, 2013). It is estimated that 56,000 RI citizens who presently have no health insurance, will obtain insurance under the Affordable Care Act (ACA), once the Health Source RI is fully operational (Kaiser Foundation, July, 2013). Of that number, 38,000 will be added through the Medicaid expansion. This dramatic increase in the number of patients needing health care will place an undo burden on the health care system in RI, unless all barriers to the utilization of licensed NP's are removed. The primary barrier to practice in RI is the limitation placed on NP practice by the third party payers.

"Specific comments on care transformation and innovation center structure"

The alliance supports the creation of "Patient Centered Medical Homes" with the unrestricted care provided by Nurse Practitioners. While the document being reviewed does , "...encourage fair treatment of health care providers..." and the to "...expand and improve the primary care infrastructure." (RI State Health Care Innovation Plan, 2013, p. 21), this cannot be accomplished without the inclusion of all providers whose practice authority endorses their rights to function as primary care providers. Certified nurse practitioners (CNP's) licensed to practice in RI, no longer, by law, must practice under physician supervision (Nurse Practice Act, 2013), however credentialing agreements for third party payers doing business in RI continue to require this relationship. By adopting provider neutral language throughout this proposed plan, it helps to endorse the ability for NPs to work as autonomous members of the health care team. In addition to the RI Nurse Practice Act, the Patient Protection and Affordable Care Act prohibits discrimination by third party payers of all health care providers. The following is a section from the PPACA:

New § 2706(a) of Public Health Service Act, created by § 1201 of Patient
> Protection and Affordable Care Act ("PPACA")
> – "A group health plan and a health insurance issuer offering group or individual
> health insurance coverage shall not discriminate with respect to participation

T> the plan or coverage against any health care provider who is acting within the
> scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer
> contract with any health care provider willing to abide by the terms and conditions
> for participation established by the plan or issuer. Nothing in this section shall be
> construed as preventing a group health plan, a health insurance issuer, or the
> Secretary from establishing varying reimbursement rates based on quality or
> performance measures." 42 U.S.C. §300gg-5(a).

This mandate should be considered by the Lt. Governor's office before finalizing the language of the "Healthcare Innovation Plan".

"Targets for transition to value based care..."

Phasing in NP's as primary care providers of record with patient panels over a 5 year period would set the standard so that all health care practices, both public and private, could add another health care provider skilled in the diagnosis and management of preventive, acute and chronic health care issues. Participation in individual and group patient appointments to provide oversight of chronic diseases, for instance, could serve as a viable model where value based patient outcome measurement could be easily undertaken. NP's have also demonstrated the abilities to assist in positive health care transitions while decreasing numbers of emergency department visits and hospitalizations for clients in long term care facilities (Newhouse, 2011; Robert Wood Johnson Foundation, 2012).

As noted by the Robert Wood Johnson Foundation (2012), health care to the uninsured, isolated and medically vulnerable is grossly under recognized in this country. This coupled with the fact that fewer than ever physicians enter primary care residencies, points to the need that NP's should be recognized as primary health care providers, working to their full practice authority in RI to make the Healthcare Innovation Plan a success.
References submitted by request.

Respectfully submitted,

Denise Coppa

Denise Coppa, PhD, RNP
President
Nurse Practitioner Alliance of RI

Office of the Lt. Governor
State House Room 116
Providence, RI, 02903
ATTN: Public Comments

RE: Rhode Island's State Healthcare Innovation Plan

November 25th, 2013

Dear Lt. Governor Roberts,

Thank you for the opportunity to comment on the State Healthcare Innovation Plan. It is clear from this report that the professionals and stakeholders assembled for this project have done a commendable job assembling information on all the various pieces that will make up a more patient centered, effective health care system for Rhode Islanders.

The Rhode Island State Nurses Association, as the professional association representing the nurses of RI is committed to continue to be active in the work of the committee and various work groups. We are excited about the opportunity to positively affect the health of Rhode Islanders. Please find our comments which we are hopeful will be incorporated as the state moves forward with this innovative plan.

- The Workstream taskforce on Workforce and Practice Transformation recommended that the term "physician extender" be eliminated. The term "health care provider" would allow for each provider to work within the scope of practice and education.
- Language around primary care physicians should be changed to reflect the importance of advanced practice nurses in the provision of high quality primary care. This is important in all areas but of particular importance in the medical home model.

- The plan calls for growing the PCMH model, please ensure that nurse care coordination is funded and incentivized.
- Lastly, we would suggest, as other stakeholders and advocates have expressed, that the plan include a robust attention to addressing the social determinants of health in order to focus on primary prevention.

Again, we thank you for this opportunity to participate in this exciting work.

Very best regards,

Chris Gadbois, MSN, RN-BC, CDDN, PHCNS-BC
President, Rhode Island State Nurses Association
150 Washington St, Providence, RI 02903

Healthcentric Advisors
Advancing Healthcare Quality | Empowering People

November 22, 2013

Lieutenant Governor Elizabeth Roberts
State of Rhode Island
Attention: SHIP Public Comments
State House Room 116
Providence, RI 02903

Re: Public Comments/Recommendations on the Draft State Health Care Innovation Plan (SHIP)

Dear Lieutenant Governor:

On behalf of Healthcentric Advisors I am pleased to submit my organization's public comments and recommendations regarding the draft of the State Health Care Innovation Plan released on November 6, 2013. The draft SHIP, as presented, is an excellent roadmap for how Rhode Island needs to continue its transition to a high quality, high value, performance-based and patient-focused healthcare delivery system.

Our submission has a twofold purpose. First, it is our intention to provide meaningful and objective commentary and contributions towards the final version of the SHIP. Secondly, we wish to share additional information regarding other important healthcare reform efforts and initiatives that were not referenced in the draft SHIP or would benefit from a more complete description or explanation. In particular, the SHIP failed to fully describe the healthcare reform efforts, initiatives and programs of Healthcentric Advisors in the areas of (1) Electronic Health Record adoption and optimization; (2) physician practice transformation (i.e. PCMH/team-based care); (3) safe care transitions/readmissions reduction; and (4) HIT workforce job training.

Assuming acceptance by the Centers for Medicare and Medicaid Services and funding of a subsequent application by the State of Rhode Island, Healthcentric Advisors stands ready to assist the State in the implementation of the final SHIP.

We look forward to sharing our experience and subject matter expertise with the State of Rhode Island in the following areas:

1. Project Management - we have over 18 years of experience developing and deploying complex healthcare quality improvement and patient safety initiatives, engagements and programs.
2. Serving as a Neutral Convener – we are viewed by healthcare stakeholders from all settings as one of the State's key neutral convener organizations for education, technical assistance and policy development.
3. Contract Administration – we have received outstanding reviews for our administration of over $53 million in federal and state contracts over the past 10 years.
4. Educational Expertise – we have solid corporate experience in providing meaningful and effective education in collaboratives and large group environments as well as individual provider hands-on technical assistance and guidance.
5. Physician and Ambulatory Practice Transformation Services – we have a long history in Rhode Island providing physician practice transformation advisory services including the full range of EHR implementation/optimization, PCMH and team care assistance.
6. Care Transitions/Readmissions Reduction Efforts – we are a nationally recognized subject matter expert in this area.
7. Healthcare Quality Improvement knowledge – we have solid experience providing quality improvement technical assistance in all settings, from outpatient to acute-care to long-term care.
8. Patient Engagement Knowledge – through our many quality improvement contracts and engagements we have developed expertise and skill sets in the areas of patient activation and engagement.

Thank you for this opportunity to comment on an excellent draft SHIP. We look forward to continuing to partner with you and your staff on future healthcare delivery reform initiatives.

Respectfully yours,

H. John Keimig, MHA, FACHE
President and Chief Executive Officer

Current SHIP Language	Healthcentric Advisors' Comment
Location: Chapter 2 / Page 14 Description of Healthcentric Advisors under "Other Important Members of the Healthcare Community"	*Request:* *Please describe Healthcentric Advisors in the following manner which is a more accurate representation of our mission and current role in the state's healthcare delivery system:* With 18 years of experience, Healthcentric Advisors is a local nonprofit organization providing healthcare quality improvement patient safety technical assistance, analytical, educational, research, and project management services. The organization has a history of working with and for state and federal government agencies, healthcare providers, research organizations and other national and community entities. Healthcentric Advisors is known for its subject matter expertise in physician office practice transformation, care transitions and readmissions reduction, and making providers' quality data meaningful and actionable. A principal role for Healthcentric Advisors is serving as the Medicare Quality Improvement Organization contractor for the State of Rhode Island. The organization is viewed as one of the State's neutral conveners by assisting healthcare providers in all settings to successfully implement new quality improvement initiatives. Its voluntary board of directors has representation from the healthcare, business, and consumer communities.
Location: Chapter 2 / Page 16/Paragraph 2 Description of the DOH HIT survey	*Suggest editing paragraph 2 on page 16 in the SHIP, with the following paragraph to provide the reader with the context in which the physician HIT survey is administered:* HEALTH's Healthcare Quality Reporting Program is a legislatively-mandated public reporting program that is led by HEALTH's contractor, Healthcentric Advisors. The program surveys physicians annually about their EMR and e-prescribing adoption. In 2013, the program administered the survey to 3,799 physicians licensed in Rhode Island, in active practice, and located in Rhode Island, Connecticut or Massachusetts. The response rate was 62.3% (n=2,367) (HEALTH, 2013). The following table shows current trends for EHR adoption and use, as well as e-prescribing adoption.
Location: Chapter 2 / Page 16 & 17 Electronic Health Record (EHR) Adoption	*Recommend adding the following language to the SHIP, to reflect additional EHR provider activities within the RI healthcare landscape:* Healthcentric Advisors has a long history working with providers to transition from paper records, optimize their EHRs and quality data reporting workflows, and make data actionable and impactful for clinical interventions. As the Medicare Quality Improvement Organization for the State of Rhode Island, Healthcentric Advisors began working with some of the first practices in the state to implement EHRs and integrate them into existing clinical processes, within *The Doctors' Office Quality Information Technology* (DOQ-IT) program. Two additional EHR / Health IT quality improvement contracts for physician offices have followed DOQ-IT, supporting those early adopters with advanced quality endeavors as well as meeting the needs of practices struggling with the pace of change. In 2008, work focused on partnering with physicians to

Current SHIP Language	Healthcentric Advisors' Comment
	improve preventive health outcomes by helping them interpret and take action on clinical quality metrics via consistent data capture, interpretive analytics, and electronic clinical decision supports. Healthcentric Advisors most recent physician office quality contract which began in 2012, *Improving the Health for Populations and Communities* focuses on advanced principles of EHR optimization, care team transformation, and patient engagement. Examples include: • Harmonizing project quality improvement measures including: o Meaningful Use o Physician Quality Reporting System (PQRS) o Healthy People 2020 o The ABCS of the Million Hearts Campaign o NCQA PCMH Standards • Capturing, reporting and analyzing EHR data to identify trends and outcomes, redesigning workflows • Promoting peer-networking, direct electronic messaging and provider compacts between PCPs and specialists to support patient co-management • Promotion of EHR utilization for patient education tools and visit summaries Additionally, the organization expanded its EHR quality improvement work to support broader practice transformation, including on-site support to federally qualified health centers, helping them adopt patient-centered care teams, and take the essential, foundational steps to become Medical Homes.
Location: Chapter 2 / Page 27 Safe Transitions Program	*Recommend an addition to the current language in the SHIP to more accurately reflect the impact of the safe transitions program on the state's healthcare delivery system:* Healthcentric Advisors has been working with healthcare providers and other community organizations since 2008 to improve transitions of care for Rhode Islanders and reduce avoidable hospital readmissions through education, research, and technical assistance. Healthcentric Advisors' Safe Transitions program provides support to individual providers who are implementing evidence-based interventions to reduce hospital readmissions and the Safe Transitions program has also formed regional coalitions that work to identify opportunities to improve care transitions in their community. The program has also established setting-specific Best Practice Measures, creating measurable, communitywide standards for patient activation and cross-setting communication. One of Rhode Island's five care transitions community coalitions, Washington County was recognized by CMS for achieving one of top Relative Improvement Rate (RIR) for Readmissions per 1,000 Medicare FFS Beneficiaries. In late 2013, Healthcentric Advisors started expanding the Safe Transition effort, with a special EOHHS-funded learning collaborative that will explore communication opportunities between hospitals and community providers at the time of discharge.
Location: Chapter 2 / Page 29 Federally Supported Healthcare Information Efforts in Rhode Island	*Recommend including the following federally supported HIT efforts into SHIP:*

Current SHIP Language	Healthcentric Advisors' Comment
	U.S. Dept. of Labor Community-Based Job-Training Program. From 2010-2013, the New England Institute of Technology (NEIT) and Healthcentric Advisors received a $2.8 million grant as part of the U.S. Dept. of Labor Community-Based Job-Training program. The goal was to maximize the expertise of Rhode Island healthcare workers with state-of-the-art training in EHRs and prepare healthcare workers for the federally-mandated 2014 deadline to institute EHRs in all sectors of the industry. Designed to meet the training needs of those who work in physician offices, long-term care facilities and hospitals, the program offered tuition-free classes at three different skill levels: entry, intermediate and advanced. The program also included preparation for the nationally-recognized Certified Professional Electronic Health Record (CPEHR) exam or Electronic Health Record Specialist Certification (CEHRS) exam. The grant program's Advisory Committee, made up of industry, educational and community representatives, provided input into the curriculum's design and identified upgrades needed to ensure relevant training for the students. Over 600 students participated in the program, 98% of whom were employed in healthcare. The program resulted in over 340 individuals sitting for one of the two nationally-recognized certification exams. To support a sustainable, standardized resource in the community, NEIT and Healthcentric Advisors were able develop a curriculum from this grant to build a new Health Informatics degree program for the school. NEIT allowed students enrolled in the HIT Job-Based Training courses to receive transferable college credits for the Health Informatics degree requirements.
Location: Chapter 3 / Page 31 Healthcare Challenge #3	*Comment:* The process by which patients move from hospitals to other care settings is increasingly problematic as hospitals shorten lengths of stay and as care becomes more fragmented. In general, hospital readmission and healthcare utilization rates vary substantially across geographic locations, suggesting opportunities for improvement in areas with higher observed rates, such as Rhode Island.
Location: Chapter 3 / Page 33 Healthcare Challenge #7	*Comment / Clarification:* Rhode Island has a 15-year-old legislatively-mandated Healthcare Quality Reporting Program that requires HEALTH to publish comparative information on providers' clinical quality measures and patient satisfaction, with the dual goals of informing patient decision making and driving market-side quality improvement. The program has an established stakeholder committee structure, Chaired by Dr. Fine, that prioritizes reporting topics and advises HEALTH and its contractor, Healthcentric Advisors, on the creation of the public reports available at: www.health.ri.gov/programs/healthcarequalityreporting/index.php
Location: Chapter 3 / Page 33 Healthcare Challenge # 8: There are unrealized opportunities for the healthcare system to incent higher levels of patient	*Comment:* Unrealized opportunities for patient engagement result from influences

Current SHIP Language	Healthcentric Advisors' Comment
engagement	on both sides of the patient-provider relationship. Patient activation could be stymied if healthcare consumers are unaware of this new type of delivery system. However, patients have a number of other factors impacting their ability to proactively self-manage their healthcare. These include: patient health literacy, cultural norms and biases, age, and other social impacts. Providers too, play a key role in the success of their patient's level of engagement. Many providers practicing in the traditional, fee-for-service model, do not have a clear understanding or are resistant to moving to a shared decision making model with their patients. Further, while they may be motivated to activate their patients, providers may not have the appropriate knowledge, tools and care team staff models in place to address the barriers their patients face, setting both sides up for uncertainly and insecurity.
Location: Chapter 4 / Page 36 RI's Healthcare Goals: Targets: • 30-day all-cause readmission • 30-day readmissions after hospitalization for behavioral health	*Recommendation:* We suggest the SHIP 1) replace the two readmission measures (30-day all-cause readmission and 30-day readmissions after hospitalization for behavioral health) with two measures of unplanned utilization, one for acute-care admissions and one for behavioral health admissions, and 2) expand the time period from 30 days to 90 or 180 days. *Justification:* In June 2013, Healthcentric Advisors published a commentary in the *American Journal of Managed Care*, articulating the need to shift from focusing on hospital visits and readmissions to bundled measures of unplanned care. The authors used Rhode Island data to demonstrate that readmission rates provide an incomplete picture of unplanned care and costs and may lead to unintended consequences, such as increased observation stay rates. In lieu of readmissions, we suggest that the SHIP calculate post-discharge unplanned utilization, including ED visits, hospitalizations and observation stays (as proposed in our commentary) and urgent care visits. This would allow the state to examine a more complete picture of post-discharge utilization and also to calculate bundled costs, helping to assess the SHIP's impact on the three-part aim.
Location: Chapter 4 / Page 36 Request input on selecting set of appropriate population health targets from these or other programs	*Comment:* Physicians are tasked with tracking, attesting and sustaining success for a number of clinical quality metrics, across a variety of initiatives and stakeholders. Harmonizing measures appropriate for PCPs and specialists alike and creating pathways to consolidate reporting will ease the burden on the providers and create a cohesive, foundation upon which the state can build. *Recommendation:* We suggest identifying the population health measures currently being utilized locally as a starting point for review and potential expansion. Healthcentric Advisors' is currently working with ~ 150 providers on preventive health measures and the Million Hearts Campaign *ABCS* (Aspirin Therapy, Blood Pressure Control, Cholesterol Management, and Smoking Cessation) via PQRS. Alignment with other QI initiatives (*Meaningful Use, PCMH, and Healthy People 2020*) has been demonstrated through this project. These providers and their care teams in both the PCP and cardiology community have been tracking,

Current SHIP Language	Healthcentric Advisors' Comment
	trending, and submitting data for PQRS measurement reporting for the past two years.
Location: Chapter 5 / Page 54 Request comments on the care transformation and innovation center regarding its structure and specific activities.	*Comment:* (Please see addendum 2 for detailed comments and recommendations)
Location: Chapter 5 / Page 55 Provide Technical Assistance	*Comment:* To ensure success and sustainability across the continuum of care, technical assistance for providers goes beyond primary care physicians and includes community health center staff, specialists, long-term care providers, urgent care staff, home health teams and other community-based organization staff members.
Location: Chapter 5 / Page 55 Use regulatory and purchasing powers to set contracting standards	*Recommendation:* The selected targets for the transition to value-based care should show linkage and alignment with goals # 3 and # 4 of the SHIP.
Location: Chapter 5 / Page 56 Expanding the Use of Community Health Teams	*Recommendation:* We suggest SHIP further clarify expanding the use of Community Health Teams to include details regarding ownership options, cost sharing, incentives and payment structures.
Location: Chapter 5 / Page 57 Centralized Aggregation Entity… to educate the public on the value of transparency and a centralized health information system."	*Comment:* The Centralized Aggregation Entity outlined within the SHIP suggests the opportunity to provide healthcare consumers a higher level of transparency about the quality and value of care they are currently receiving. However, sharing physician metrics on cost, quality, and outcomes at a statewide level should coincide with data support and resources at the provider level; the majority of physician offices lack the data analytic teams in place to both *interpret* quality data (whether provided internally via their EHR or from external sources) and to make it *actionable* for sustainable improvement. *Recommendation:* The SHIP should clearly identify and outline interpretive analytic resources that can be accessed by physician offices to mitigate or improve upon any aggregate, statewide metrics shared publically.
Location: Chapter 5 / Page 59 Promotion of Health Information Technology and Measurement	*Comment:* It is important to consider the other HIT measurement initiatives actively underway locally, within physician offices. Healthcentric Advisors is

Current SHIP Language	Healthcentric Advisors' Comment
	working with a number of providers to electronically track and submit PQRS reporting metrics both via claims and directly via their EHRs. The practices reporting PQRS measures with an EHR are some of the first physicians in the country, piloting this approach with CMS. Beginning in 2013, all provider practices are required to report to PQRS to either receive a payment incentive or payment adjustment for the *CMS Physician Feedback / Value-Based Payment Modifier Program*. PQRS will serve as the reporting mechanism for this program, which will begin in 2015 to provide a Medicare FFS increase or adjustment on all FFS payments (based on the *2013 reporting year*): http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRI/. The PQRS program will continue to increase harmonization of its measures to the Clinical Quality Measures (CQMs) within Stage 2 of the Meaningful Use incentive program. *Recommendation:* To ensure alignment and efficiency for physician offices and their staff, SHIP should include an environmental scan of the additional quality reporting initiatives providers are/will need to measure and report.
Location: Chapter 5 / Page 60 Workforce Development: Conduct a Workforce Assessment	*Recommendation:* Regarding the section on page 60, *Conduct a Workforce Assessment*, the writers may want to reference the existing work of the Governor's Workforce Board (GWB). In 2014, GWB will be conducting a workforce skills gap study, building off their past studies. The study will be joint effort between GWB's Healthcare Industry Partners: Healthcentric Advisors, Stepping Up, and the Hospital Association of Rhode Island.
Location: Chapter 5 / Page 61/63 Patient Engagement	*Comment:* Patient engagement is an essential piece of the puzzle for person-centered care and shared decision making. Engaging patients and their families yields better outcomes and supports the triple aim. But the root of the activated patient is found in their attitudes, beliefs, and behaviors about self-managing their health. Cultural norms, family dynamics, age, social impacts and an individual's health literacy all influence how a patient will respond to this new model of care. This transformative approach also lacks a succinct roadmap for many care providers to implement a more collaborative relationship with their patients. Additionally, providers need to identify other key members of their care teams to share in the responsibility of patient engagement. *Recommendation:* RICTIC should create training and resources for both healthcare consumers and healthcare providers, to support both parties in this new dynamic of shared decision making, taking into consideration the influences and barriers that impede patient engagement and offering tools to mitigate them.

Addendum 1

Issue Brief: Care Transitions Accomplishments

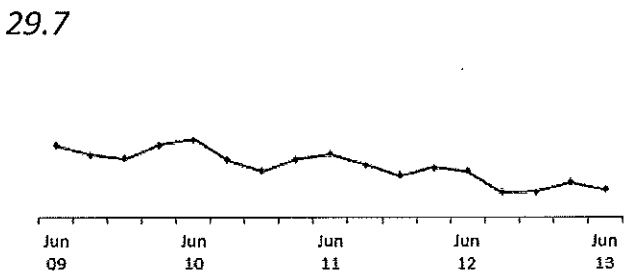
Healthcentric Advisors

A Preeminent National Leader in Care Transitions
Research, Education, Publication, Facilitation and Implementation

Since 2008, Healthcentric Advisors has successfully partnered with healthcare providers and stakeholders to improve the care, quality and costs associated with Rhode Island patients' transitions from one setting to another.

Rhode Island's Medicare readmissions rate has decreased 6.0 per 1,000 patients since January 2009.

Rhode Island Hospital Readmissions Rates per 1,000 Medicare Beneficiaries



Semi-Annual Rates

What has Healthcentric Advisors accomplished?

✓ **Healthcentric Advisors was the first in Rhode Island to introduce the concept of care transitions to providers, payors and the public.**	*Due to our leadership, expertise, and national reputation, we were one of only 14 Medicare Quality Improvement Organization (QIO) contractors to be awarded a prestigious Medicare care transitions special study in 2008.*
✓ **Our national leadership in care transitions and reducing avoidable readmissions has had a positive financial impact on Rhode Island.**	*We have brought ~$8 million in federal funding to our state to improve care transitions—and have partnered with other entities to secure additional funding state in this area.*
✓ **We were the first organization in the nation to frame care transitions as a patient safety goal.**	*The nation (CMS, other QIOs, hospitals, and other provider entities) has followed our lead, adopting this perspective; this aligns care transitions with the National Quality Strategy and three-part Aim.*
✓ **We were the only recipient of the Medicare care transitions special study to partner with two national leaders.**	*Dr. Eric Coleman (University of Colorado) and Dr. Brian Jack (Boston Medical Center) co-chaired the Healthcentric Advisors' Safe Transitions Advisory Board from 2009 until 2012, giving Advisory Board members direct access to two pre-eminent care transitions researchers.*

What has Healthcentric Advisors accomplished?

✓ **As a result of our work, Rhode Island is the only state in the country to universally adopt evidence-based care transitions best practices for hospitals and incorporate them into hospital contracting.**	*We created and facilitated the adoption of care transitions best practices throughout the state, including hospital best practices. Our best practices also include EDs, home health agencies, physician offices, nursing homes and urgent care centers.*
✓ **Our care transitions work has been recognized by state legislative and government leaders.**	*The Office of the Health Insurance Commissioner directed health plans to incorporate our care transitions practices into their hospital contracting.* *The General Assembly acknowledged our accomplishments by directing hospitals to participate in a transitions project.*
✓ **We are among the nation's leading educators and advisors in the area of care transitions and reducing avoidable hospital readmissions.**	*Locally, we lead 5 regional care transitions coalitions and a statewide learning and action network. We also provide expertise and consultation to concurrent initiatives, such as bundled payment and the Community-Based Care Transitions Program.* *Nationally, our team regularly presents at national conferences. In 2012, our accomplishments were profiled in a national Medicare Webinar.* *In 2011, we hosted a nationally-recognized Transitions Summit during which local and national care transitions leaders and experts developed a shared vision for care transitions in Rhode Island.*
✓ **We are among the nation's leading publishers of care transitions research, results, information and recommendations**	*We were the first to prove the real-world efficacy of Dr. Coleman's patient coaching, with results published in the* Archives of Internal Medicine. *Our work has been published and referenced in leading medical and healthcare journals.* *We receive frequent requests from research journals to serve as peer-reviewers for care transitions manuscripts.*
✓ **Our work has produced tangible results and solid improvement in healthcare quality and patient safety for Rhode Islanders.**	*All Rhode Island providers are now focused on care transitions. As a result of our collaboration and leadership, Medicare readmission rates are declining in Rhode Island, leading to improved patient outcomes and generating cost avoidance.*

H. John Keimig, MHA, FACHE, President & CEO
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Public Comment to: Chapter 5 / Page 54

Structure and Activities of the Proposed Rhode Island Care Transformation and Innovation Center (RICTIC)

I. Recommended Organizational Structure Attributes

- Public – private partnership where the State contracts with an existing private 501c (3) community entity to serve as an umbrella organization for the RICTIC.
- The umbrella organization would be responsible for the overall development, implementation and administration of the RICTIC.
- A *Leadership Advisory Board* (LAB) would be established to provide oversight of the RICTIC and establish its priorities and monitor its performance against goals and objectives.
- The LAB would be composed of physicians, consumers, payers, purchasers, institutional providers, state government representatives, educators and other community healthcare, social service and related organizations.
- The umbrella organization would subcontract with other organizations, agencies, and entities on an as needed basis in order to successfully achieve the goals and objectives of the RICTIC.

II. Recommended Competencies and Credentials of the RICTIC

- Track record of successfully working with providers in all settings - cross-setting and individually (hospital, nursing home, home care, community health center, and physician office settings).
- Track record of successfully administering state and federal contracts.
- Track record of successfully working with state agencies and departments.
- Trusted and experienced neutral community convener.
- Solid project management experience.
- Extensive quality improvement technical assistance experience.
- Solid analytics experience (including data aggregation, database management, outcomes reporting and interpretive analytics).
- Experience in measures development.
- Experience in administering education collaboratives and learning and action networks.
- Experience in providing EHR consulting and advisory services (readiness assessment, pre-implementation planning, implementation, and optimization).
- Staff with NCQA's *Patient Centered Medical Home Content Certification (PCMH CCE)*
- Care transitions subject matter expertise.
- Physician office and ambulatory care setting practice transformation consulting and advisory experience.
- (Proven) Knowledge of workforce development efforts.
- Research and peer-reviewed publication experience.

III. Recommended Roles and Activities of the RICTIC

- Serve as the state's central repository and hub for healthcare transformation, ACO and value-based purchasing education, knowledge, resources, and technical assistance.
- Provide large group, collaborative format learning and educational programming.
- Create and administer remote learning opportunities for providers.
- Provide customized individual technical assistance to providers on:
    - Patient Centered Medical Home
    - Expansion to Medical Neighborhoods
    - Practice Transformation
    - Care Coordination
    - Team-based Care
    - Admission/Readmission Reduction
    - EHR Optimization (*beyond* Meaningful Use)
    - Interpretive Analytics Services
    - PQRS
    - Quality Improvement Techniques and Applications
    - Patient Engagement and Activation
    - Cultural Competency
    - Health Literacy

- Serve as the principal convener of stakeholder organizations and coalitions relating to the implementation of the State Healthcare Innovation Plan.
- Provision of analytical information and interpretation for providers.
- Serve as an incubator for new models of value-based care.
- Serve as a resource for patient activation and engagement including advance care planning.
- Work with the RIQI to advance CurrentCare throughout the state

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Rhode Island Chapter

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November 19, 2013

Lt. Gov. Elizabeth Roberts
State House
Providence RI 02903

Dear Lt. Gov. Roberts,

As pediatricians and enthusiastic participants in your health care reform efforts, we are impressed by the excellent information and the health care innovations in the *HEALTHY Rhode Island [HRI]* draft now out for comment. We are impressed by the vigorous, inclusive process of planning. We have previously submitted some specific suggestions about medical homes for children (letter of 23 Sept).

However, we are still very concerned about *HEALTHY Rhode Island's* narrow focus on the problems, costs, and options for adults' medical care, with only light, late, and limited attention to children's life trajectory/ prevention issues, and to public health. We worry that *HRI* will be seen as the state's plan for health budgets, and that basic, effective and cost-effective investments beginning in infancy and continuing throughout childhood and youth will be neglected. Preventive medicine cannot truly occur once children are damaged from obesity, mental stress and myriad effects of inadequate healthcare and poverty.

While it is very important to improve the effectiveness, equity, and excessive expense of American medical care, that cannot be achieved without serious, sustained investments in healthy child development, public health, and primary prevention for everyone. In this draft of HRI, prevention is touched here and there, children are mentioned only twice, and public health only on the last page.

Rhode Island's children and youth deserve a seat at this table. The State Innovation Plan should include:

- strong support for children's medical homes (PCMH Kids), including
- robust developmental/behavioral health care and the creation of a true behavioral health system for kids,
- promoting parent and patient roles in all of our reform efforts,
- explicit support for public health integration into our primary care model and
- workforce development for these approaches.

Therefore, we recommend that the *HEALTHY Rhode Island* plan be broadened to include children's and community health needs, even if those

needs are not addressed in the same detail. We would be happy to assist with drafting.

There are some good starting points in the "6 pillars" of HRI:

> **#3. Patient/Consumer Centric.** Family centered health management is critical to humans' success. RI has built medical homes and peer parent models of kids' care that give better outcomes and lower costs. These models need solid funding.
>
> **#4/5 Transparency and Accountability** will require good population health data. Public health data seldom come from medical claims (or even from EHRs) KIDSNET is a unique RI asset, helpful for good care, and for measuring how well we reach all children with essential services.
>
> **#6 Community Assets** are the real foundation of healthy child development, and of public health. RI has shown how to help parents become part of community assets, through family centered medical homes.

A long healthy life begins at the beginning – infancy (actually before conception) – and is built and protected through the first decades by effective parents, healthy neighborhoods, good schools, and by excellent pediatric care. Rhode Island has been enlightened in its tradition of stalwart support for immunizations, for protection from lead and other hazards, for KIDSNET data, for parent engagement in medical homes, and for RIte Care.

We believe those priorities should be woven into the text of *HEALTHY Rhode Island*, or perhaps it would be even more powerful to draft a new chapter on children, primary prevention, and public health. Without that, the plan may achieve some useful innovations in adult medical care, but it won't address lifelong health, or reduce ruinous future medical costs.

We would be grateful for an opportunity to discuss these concerns directly with you and your staff.

Sincerely,

William H. Hollinshead, MD MPH, FAAP
President
American Academy of Pediatrics
Rhode Island Chapter

Public Comments

Matt Forster <bracesnewport@gmail.com> Wed, Nov 20, 2013 at 9:21 AM
To: shipcomments@ltgov.state.ri.us

To whom it may concern:
Thank you for the opportunity to voice an opinion regarding this matter.
Unfortunately, I was never asked to do so before Obamacare was mandated for all of us. Now it seems moot this show of "listening".

As a small business owner, I purchase BCBS personally for myself, wife and three kids, which is no small feat, but we were happy with our coverage. We just received notification that our premium will go up for my family $400 next year. That is a 50% increase. It will force me to shop on your exchange for a comparable policy if that exists. I have no desire to do so given the amount of personal information that needs to be reported over an unsecure and untested website and the amount of extra time I am now forced to undertake. We are busy and I do not have spare time to sit at a government office to do this in person. It saddens me that you and your staff have endorsed this change to help some people while hurting a lot of other hard working people. If given the opportunity to voice opinions before this debacle, I would have proposed different ideas to help businesses so they could create more jobs. This new policy in no way helps businesses, and I would think this state should focus on that rather than increasing entitlements and creating disincentives to work.

Once again, my government and community is failing me on a state level and I am joining the growing tide of reform in this state. Enough is enough, please get rid of this health system you are forcing on us and stop spending all this money on marketing and advertising. It is sickening.

Thanks for the opportunity to respond.

CMF

--
Dr. Matt Forster, DMD
www.ForsterOrthodontics.com

Dan Meuse <dmeuse@ltgov.state.ri.us>

Healthcare Roadmap "payment rooted in value"?

Peter Lodge <peter.lodge48@gmail.com> Tue, Nov 12, 2013 at 12:08 PM
To: shipcomments@ltgov.state.ri.us

If this plan is to be successful policy wonks such as the one who wrote the preface should be banned from any involvement in its development and implementation. Providers of services in the current 'broken plan" are painfully aware of the shortcomings and can best describe a workable framework for the future.
If on the other the unsaid goal is to create an new bureaucracy of regulators regulating regulators who deny payment for services ...slog on. By the way....what does payment rooted in value mean?

Peter J. Lodge D.M.D.
Narragansett, R.I.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Administration
DIVISION OF PLANNING
One Capitol Hill
Providence, RI 02908-5870

November 12, 2013

Lt. Governor Elizabeth Roberts
Office of the Lt. Governor
State House Room 116
Providence, RI 02903

Dear Lt. Governor Roberts:

I am writing to express my support and enthusiasm for the State Healthcare Innovation Plan (SHIP) as presented for public comment on November 6, 2013. The Division of Planning has been honored to be a part of the plan's development and I am especially delighted to see the plan's consideration and integration of the social determinants of health and non-traditional approaches to improving the health of Rhode Islanders.

The Division of Planning is ready and willing to partner with other State agencies and community-partners to increase awareness and understanding of the social determinants of health, as described on page 63 of the SHIP. It is becoming increasingly clear that the land use, transportation, housing and other decisions made at the local level have a direct impact on resident health. Through smart planning, local governments and the State can actively improve the health of Rhode Island's current and future populations, but we must first realize and understand the impacts of our decisions on health.

Also, the creation of a Healthcare Innovation Trust Fund is of particular interest to the Division of Planning, in that it could assist municipalities in funding built environment projects that will have long lasting positive impacts on the health of residents. While the common understanding of healthcare is in the provision of health services, the Healthcare Innovation Trust Fund could be used to inspire real innovation in addressing the social determinants of health and built environment impacts by funding community-based projects.

Please know how much we value continuing our work together on this valuable initiative. We look forward to collaborating with you to sustain this work in the coming years.

Sincerely,

Kevin Flynn
Associate Director
Rhode Island Division of Planning

Dan Meuse <dmeuse@ltgov.state.ri.us>

ACA

John Laiho <john-laiho@cox.net> Sun, Nov 10, 2013 at 11:50 AM
To: shipcomments@ltgov.state.ri.us

To Whom It May Concern:

I was probably one of the first people to sign up my wife and I on the exchanges. It took several hours to do so over the phone, and I needed to visit the main office in Providence to prove my identity. That being said, it was well worth my time. My wife and I will save thousands in monthly premiums due to the tax subsidies. Our current policy with BC/BS has a premium of $1315 per month. Starting in January, the premium will be $345 per month. The new policy deductibles ($2600/$5200) vs. the old plan ($1500/ $3000), will be higher as well as the maximum out of pocket expenses; the old plan ($3000/$6000) vs. the new plan($4000/$8000). In the worst case in which both of us max out, we will still save thousands of dollars. For example:

12 *$1315=$15780+$6000=$21780 old plan

12*$345=$4140+$8000=$12140 new plan Savings of $9640

While the new plan has considerable savings, how affordable would $12140 per year be if our health were to take a turn for the worse? And, how many Rhode Islanders would find this amount affordable even with tax subsidies?

I realize there are other considerations that make the ACA a vast improvement over the status quo. The elimination of pre-existing conditions and lifetime limits, raising the eligibility age of children to 26 years old, and covering preventative services to mention a few. Not to mention many who did not have health insurance will now have it.

The good news is that we are making progress. A good first step.

However, I would like to point out that my wife and I are looking forward to being eligible for Medicare in a year and a half. Yes, we will still need to purchase a gap plan from the private insurers, to cover what Medicare does not, but we will not have the exposure to large deductibles and out of pocket maximums.

Vermont is trying to implement a state Medicare program. Long term, Rhode Island should be looking to do the same. There are some states which are being dragged kicking and screaming to provide health insurance to their citizens. Rhode Island is not one of them. Like Vermont and Rhode Island, there are other states which embrace reforms, particularly in the Northeast. A regional approach to implementing single payer health insurance for the states amenable to reform should be explored. Think of our children and grandchildren avoiding the morass of the private insurance market place.

Again, a good first step setting up the RI Health Insurance Exchange. What can we do to make things better?

John Laiho

76 Hampton Way

Wakefield RI

Dan Meuse <dmeuse@ltgov.state.ri.us>

Discontent

John Romano <jrdds82@cox.net> Fri, Nov 8, 2013 at 2:33 PM
To: shipcomments@ltgov.state.ri.us

Inviting comment from those of us who have no voice seems completely disingenuous if not dishonest. This State was founded on freedom, specifically freedom of religion, yet you have somehow empowered yourselves to decide what is best with respect to healthcare for the citizens of RI. Insurance carriers and the government are becoming increasingly involved with directly and indirectly influencing diagnosis criteria as well as treatment protocols and modalities in the care of our patients. These are changes based on economies of profit for the carriers and expense and control for the government. While some patients will surely benefit from these proposed changes, the vast majority will have their healthcare impacted negatively and told they are better off. The needs of the few, as is becoming the norm, outweigh the rights of the many, and policy is made on this basis. This new "Innovation Plan" reflects the embarrassment of the National foray into deciding what is best for its people, and it is truly embarrassing, even when veiled under the cloak of reform.

John T A Romano, DDS

Dan Meuse <dmeuse@ltgov.state.ri.us>

SHIP Comments on behalf of University Emergency Medicine Foundation

Michael Ryan <mryan@advocacysolutionsllc.com> Fri, Nov 8, 2013 at 10:29 AM
To: shipcomments@ltgov.state.ri.us

Dear Lt. Gov. Roberts:

On behalf of the physicians and staff of the Department of Emergency Medicine at the Alpert Medical School of Brown University we write to comment on the State Healthcare Innovation Plan (SHIP). Our physicians and mid-level providers staff the emergency departments at Rhode Island Hospital, The Miriam Hospital, and Hasbro Children's Hospital.

Specifically, we strongly support improving services for high utilizers of emergency departments, such as the "Sobering Centers" concept mentioned in the SHIP. The over-utilization of emergency services by chronically inebriated individuals has been well documented. At Rhode Island Hospital's Anderson Emergency Center alone, 50 patients with substance abuse accounted for more than 2,800 alcohol-related visits in 2011. Many of these visits are from individuals who have battled alcoholism and other drug addiction for years and whose needs can be met outside of a hospital emergency department.

Providing emergency services to intoxicated individuals in non-emergency situations is costly and inefficient for health-care providers, other emergency-room patients, hospitals, municipalities, and the state. Most strikingly, this cost often ultimately falls to Medicare and Medicaid who reimburse these services on a daily basis.

This current system fails to appropriately treat the individual's underlying substance abuse. The solution is to create a safe, alternative setting, where we can safely and effectively care for these clients and connect them with appropriate treatment. Not only would this approach target the root cause of this cycle of abuse, it would unburden the healthcare system.

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) along with other stakeholders have been developing a three-year pilot program known as the Sobering Treatment Opportunity Program (STOP). The STOP initiative presents an opportunity to safely divert chronically inebriated individuals from the emergency department to a more appropriate, less costly alternative setting.

The SHIP grant could greatly improve the services provided by this program. Specifically, the SHIP grant could help provide outreach services to our homeless alcoholic population to help divert this population away from the healthcare system and into the proposed program. Additionally, partnering with SHIP in this capacity would provide a more comprehensive financial analysis of this national issue and could provide a framework for CMS's approach on a larger scale.

Improving services for high utilizers of emergency room departments will require community-wide collaboration among government, health-care and social-service organizations. We believe the State Health Innovation Plan is an important step in addressing this issue through planning and implementation of best practices.

Warm Regards,

Brian Zink, MD

President, University Emergency Medicine Foundation

Chair, Department of Emergency Medicine, Brown University

Otis Warren, MD

Professor of Medicine (Clinical), Brown University

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Dan Meuse <dmeuse@ltgov.state.ri.us>

comments

Greg Gerritt <gerritt@mindspring.com> Thu, Nov 7, 2013 at 11:24 AM
To: shipcomments@ltgov.state.ri.us

On behavioral and substance issues.

Key factor for improvement: Reduce economic inequality in RI by taxing the rich more. Greg gerritt ProsperityForRI.com

Dan Meuse <dmeuse@ltgov.state.ri.us>

Healthcare

Paula Silva <paula.silva8@gmail.com> Thu, Nov 7, 2013 at 10:35 AM
To: shipcomments@ltgov.state.ri.us

Hi,

I do not have healthcare currently one reason being the system seemed so overwhelming to wrap your head around. Also,as an independent contractor and single woman it is just so expensive and I have been a very healthy person my whole life.
I recently attended one of the Healthcare summits at Rhodes of the Pawtuxet for realtors and was impressed with how simple and clearly it was presented on the worksheets provided. I still think it is extremely expensive (I am over 50) and I would definitely like to see more options available like more providers for wholistic wellness care. I have not had any experience on the website or calling the help center so I have no opinion on how that is working.
I will apply but I may take the 1st year penalty till more providers participate bringing more choice and costs down.

Otherwise, I think RI has done a great job in coming up with a clear concise path in this initial rollout.
Thanks,
--
Paula Silva

Lifespan

November 27, 2013

Timothy J. Babineau, MD
President and
Chief Executive Officer, Lifespan

President, Rhode Island Hospital

Professor of Surgery
The Warren Alpert Medical
School of Brown University

Office of the President
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Providence, RI 02903

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The Honorable Elizabeth Roberts
Lieutenant Governor
State House Room 116
Providence, RI 02903

RE: Rhode Island's State Healthcare Innovation Plan

Dear Lieutenant Governor Roberts:

Thank you for the opportunity to comment on the draft State Health Innovation Plan. We appreciate the considerable work that you have led, as well as the many health care reform efforts currently underway in both the public and private sector. This is indeed a time of unprecedented change and, as the state's largest healthcare system and primary safety net provider, we are pleased to be an active participant in the dialogue.

The plan touches on many goals and approaches about which few could quarrel. For instance, there is little debate about the value of the triple aim. The need to improve patient experience, health outcomes and lower costs are necessary goals whose achievement will address many of the deficiencies of today's health care system. Likewise, we agree that expanding primary care medical homes and encouraging enhanced patient engagement in the care system are also laudable and important goals and we fully support them.

Rather than providing a point-by-point commentary on various aspects of the narrative and elements of the plan, let us offer a few, more select, observations gleaned from a review of the draft and supporting materials.

One observation is the understated toll Rhode Island's prolonged and intractable economic slump has had on the health care system. While acknowledging the importance of economic wellbeing on health outcomes, the plan neither encourages nor supports initiatives sorely needed to advance new policies and plans for economic revitalization. Moreover, population loss (due to the poor economy) and an aging population will likely strain social service capabilities within our state. It seems conceivable that the focus on increased wrap-around social services in the health care delivery system could exacerbate the state's poor fiscal condition sometime in the future, unless successful strategies are implemented to catalyze economic growth. We realize the intent

of the SHIP was not economic development. Nonetheless, the health of the economy and the health of our delivery system are inextricably linked.

Another concern is the over-emphasis of Accountable Care Organizations and ACO like entities (the parameters of which remain undefined in the context of the SHIP) as a prime mechanism to improve health outcomes, standardize care and control cost. There is still little evidence (although it is admittedly early) that these organizations, with their inherent limitations, will deliver on these promises. Other initiatives, some already in the marketplace and others being devised, may offer greater opportunity to achieve the Triple Aim. The state should encourage (and not impede) continued evolution of several different new approaches and strategies and not limit their scope to ACO-like models. Toward this end, a more comprehensive review of existing statutory and regulatory impediments to achieving a number of the stated goals of the Plan is essential to encourage and allow the change required to better align care models. For example, the plan envisions that many patients would be enrolled in systems of care through capitated arrangements. Would fully capitated lives managed by large, multidisciplinary medical groups be regulated under the state's managed care statute? What financial and capitol resources and reserves would be required and would the state subsidize these? These and other questions need to be considered before such arrangements are finalized.

From a financial standpoint, The Plan links investment to systemic savings but the investment from CMS seems a very small part of the dollars that will ultimately be required. Lifespan and other systems are making very substantial investments in technology and other patient management tools with no similar support. For example, over the next 24 months, Lifespan will invest over $100 million to completely redesign its clinical information systems. We believe this is an essential foundation to create the new models of care required to be help enhance quality and control cost. Should this investment be acknowledged and perhaps aided? It is also important to point out that we are making these investments while simultaneously experiencing reduction in program support, burgeoning free care expenses and forecasted negative operating margins for this fiscal year and beyond.

Another concern with the design of Plan is the lack of acknowledgement of the importance of sub-specialty medicine in the co-management of complex medical conditions and their important role in our delivery system. Despite best efforts, people become ill, are victims of traumatic injury and require high end, tertiary care. Successful outcomes of high cost, complex medical cases require medical teams that include specialty and institutional care. The availability and access to these services and interventions are essential—despite high "stand by" costs—and are a critical component of a robust and inclusive system of care

that must be available in our state. Moreover, claims data suggests that these services are provided at an attractive cost when compared with similar services in neighboring states. How these services are supported and paid for (going forward) must be part of any comprehensive system redesign plan. A trauma center must function 24 X 7 X 365 for it to be effective and an acknowledgement of its value and the value of similar tertiary services must be part of any comprehensive plan. Finally, the absence of any acknowledgement of the role academic medicine has played in advancing medical care (not to mention the economy) in our state is a major concern. The lack of discussion for its stable and predictable funding in the future, we believe, is an oversight.

The Plan envisions a substantial reduction in the current funding of the health system. A closer examination reveals that, given current health care expenditures, a sizable portion of the reductions will come from hospitals within the state. Yet the plan is eerily silent on the ramifications of these reductions and the disparate roles some hospitals play in the current safety net, medical training and academics. With so much concern exhibited in recent various regulatory reviews about the economic impact of hospitals on communities, the failure to advance a holistic framework for discussion and impact is troubling.

In closing, we gratefully acknowledge the hard work and collective thinking that has gone into preparing this plan. Any effort that increases the focus and attention on health system redesign is a laudable effort. That said, it is somewhat difficult to assess, with any certainty, the impact the many initiatives articulated in the Plan will have on a system as complex, essential and far reaching as Lifespan. We are a complex organization that anchors the clinical, academic and research enterprise statewide, providing essential health services to nearly half the population of Rhode Island each year. This is an enormous responsibility, one which we take very seriously. The sweeping nature of the Plan is a vision for an enhanced delivery model and we embrace the creation of a more patient centered, value driven system of care. We remain committed to be an active participant in this important dialogue.

Again, thank you again for the opportunity to comment.

Sincerely yours,

Timothy J. Babineau, MD
President and CEO, Lifespan

Blue Cross
Blue Shield
of Rhode Island

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November 26, 2013

The Honorable Elizabeth Roberts
Lieutenant Governor
State House Room 116
Providence, RI 02903

RE: Rhode Island's State Healthcare Innovation Plan

Dear Lieutenant Governor Roberts:

Thank you for the opportunity to provide comments on the draft State Healthcare Innovation Plan (SHIP or Plan). First, I would like to acknowledge the work of your office, the multiple state agencies, and various stakeholders that assisted in the creation of the SHIP.

I understand that the SHIP is intended to describe innovations at a high level, focusing on policy ideas and strategic impact and therefore does not include detailed program descriptions and specific plans for implementation at this time. I realize that a more detailed and refined application requesting an innovation grant in the order of magnitude of $40 - $50 million will be submitted to the Center for Medicare and Medicaid Innovation (CMMI) at a later date while the current version of the SHIP will be used as a work product that demonstrates how the initial grant funding from the (CMMI) has been spent. While Blue Cross & Blue Shield of Rhode Island (BCBSRI) firmly supports innovation in our state, at this stage of development, we believe the Plan lacks the specificity, direction, and detail needed to drive meaningful transformation in the State's health care delivery system.

As you know, since my arrival at BCBSRI over 2 ½ years ago, we have dedicated ourselves to working with public and provider partners to transform the delivery system. We share a collective vision of a virtually integrated, high quality, patient-centered system of care that moves away from paying for volume to paying for value. In that time, BCBSRI and key healthcare leaders in our state have made incremental advances in several areas of payment reform, quality improvement programs, care coordination initiatives, and advancing healthcare technology and connectivity. Any success achieved in these initiatives is due to the establishment of well defined, shared, and attainable goals between the various parties. None of the accomplishments, in and of themselves, will make healthcare more affordable or higher quality, but each small innovation we achieve moves us in a meaningful way towards a true "system" of care.

While the Plan's broad description may be a function of CMMI's requirements, we believe the State - and the healthcare stakeholders charged with acting on it - will be best served by a more focused plan with incremental achievements. Therefore, we recommend that the Plan and, ultimately, the innovation grant application, be narrowed to focus on three main areas:

1. Payment and Delivery Innovations and Tools.

Through much investment and various efforts including CSI-RI and BCBSRI's own PCMH initiatives, Rhode Island has become a national leader in primary care transformation. Primary care is the cornerstone of a virtually integrated delivery system. BCBSRI and many of our partners are committed to continuing to drive the adoption of PCMH's; but, we must balance continued investments in primary care and the expansion of PCMHs with efforts to engage sub specialists in transforming their practices if we hope to achieve the goal of having 80% of Rhode Islanders under a value-based payment arrangement within 5 years.

As noted in the Plan, many healthcare providers lack the training, capital, and tools they need to transform their practices. We must give these providers the support they need. In that vein, we recommend that the Rhode Island Care Transformation and Innovation Center (RICTIC) be established with three primary goals.

First, as the Plan acknowledges, providers are at various stages of practice transformation. The RICTIC must identify providers based on where they are in their acceptance of transformation and educate those less inclined toward transformation and value-based contracting about the benefits of these efforts to the provider, their patients, and the system as a whole.

Second, the RICTIC must assist healthcare providers in obtaining and implementing electronic medical records, implementing tools for evidence based medicine, and the training necessary to implement and operate within value-based contracts. Redesigning traditional business models and implementing quality metrics will require significant change and investment in the short-term, but will yield positive long-term results as patient outcomes improve.

Last, the RICTIC can and should drive efforts to establish meaningful quality measures that are standardized across the system and based on evidence based medicine. RICTIC should be created as a non-profit entity that is a shared resource for all. It should serve as a center for data, analytics and informatics to support quality metrics for the entire healthcare delivery system. In addition, the RICTIC should leverage the All Payer Claims Database that is currently under development to minimize administrative burden. This work would facilitate the support needed in the State to harmonize quality metrics across providers, payers and regulators, and serve as the foundation for the State to drive innovation.

2. Expanding the use of Community Health Teams.

Community Health Teams (CHTs) are intended to address the lack of coordination between traditional medical/behavioral care and social services, such as housing, security, education, and food. CHTs could also include social workers, care

coordinators (especially for transitions), and other people involved in social services and health and human services. For primary care practices with only one or two physicians, which make up the majority of primary care practices in Rhode Island, CHTs are a mechanism for providing many of the fundamental functions of a PCMH. Small primary care practices do not have the size or infrastructure to support a full time nurse care manager onsite in their offices. The CHTs could serve that role for a number of practices in different geographic regions of the state. Moreover, these CHTs could also be used to support PCMHs by offering mental health and substance abuse support.

We believe that CHTs can bring significant enhancements to the healthcare system by ensuring compliance with treatment plans and identifying patients at-risk before the risk materializes in order to avoid hospitalizations and serious complications. However, the concept of having the CHTs developed through the use of OHIC's regulatory powers is not the right approach. First, CHTs benefit all Rhode Islanders – many of whom are outside the regulatory power of OHIC. Second, this must be widespread, in multiple communities and will largely benefit Medicaid and Medicare patients. As a result, it is more appropriate to fund the expansion of CHTs through the RICTIC using State and/or federal funds. Of course, payers could be encouraged through OHIC to pay for the services of CHTs as covered services under insurance plans.

The integration of CHTs with primary care providers is critical to their collective success. Therefore, we also recommend that the RICTIC establish a database of available CHTs, implement training programs, and establish mechanisms to connect CHTs with primary care practices so that referrals are seamless, fast and effective and to ensure that information can be easily transmitted.

3. Patient Engagement.

If we are to achieve value-based purchasing of healthcare services, we must ensure that patients understand their role in the healthcare system. As the Plan indicates, there are varying levels of health literacy in the State. We believe health literacy is generally low, and that individuals view the healthcare system not as a way to improve their quality of life, but as something that is there for them when they need it. We must ensure that Rhode Islanders understand the availability of services, how to access those services, and the importance of establishing a relationship with a primary care provider to obtain preventive care and to navigate what will still be a complex system when they need specialty or hospital care.

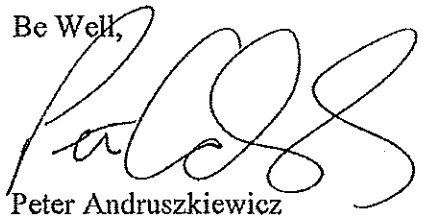
As we develop new tools for transparency and quality, we must ensure that Rhode Islanders understand how to use these tools. And, we must ensure that healthcare providers use the tools as well. We cannot underestimate the effort that is needed to get the word out about how to use a reformed delivery system.

While the three areas of focus above reflect our primary recommendations, we also urge you to rethink the Plan's treatment of Behavioral Health. We agree that cost, access, and quality of behavioral health services must be addressed. We think the Plan would provide a better foundation for future action if it provided expanded and accurate data in the Plan's "current healthcare system" and "healthcare challenges" sections. The Plan indicates the State welcomes additional suggestions for strategies to address behavioral health innovations and we are eager to participate in that conversation. To the extent the Plan concludes that mirrored co-location is the preferred behavioral healthcare innovation, even in the short term, we strongly disagree. It may be one tool, but our experience does not support widespread expansion of co-location. We recommend the Plan retain the reference to CHTs and replace co-location with a proposal to explore integration across a broad spectrum of methodologies, of which co-location may be one, but not the only, option.

In closing, I want to reiterate that no single stakeholder can achieve the goals in the Plan alone. In various areas throughout the Plan it is suggested that if movement is not made or, in some cases, in order to initiate movement, the State will intervene through regulatory processes to force change. The Plan should instead articulate that public/private partnership can lead to innovation and experimentation that will enable new and exciting health care delivery and financing models as well as better, more affordable health care outcomes for the people of Rhode Island We believe the State needs a new kind of health care system; a real system. In order to realize this goal the Plan will need to facilitate and embrace this public/ private partnership to create a new model for collaboration between the State and partners who share largely the same goals.

I hope these comments will be helpful as you finalize the content and the tone of the Plan. BCBSRI is committed to transforming the delivery system with our partners through helping providers build new models of patient centered care delivery and accelerating these efforts through innovative payment arrangements. While our work is ongoing and is not progressing as fast as many of us would like, the level of collaboration and commitment to transforming the delivery system in Rhode Island has never been greater. We must build off of this momentum, accelerate our work and together build a new model for successfully achieving the goals we all share. Thank you for the opportunity to comment on the SHIP. If you have any questions, please do not hesitate to contact me.

Be Well,



Peter Andruszkiewicz
President & CEO

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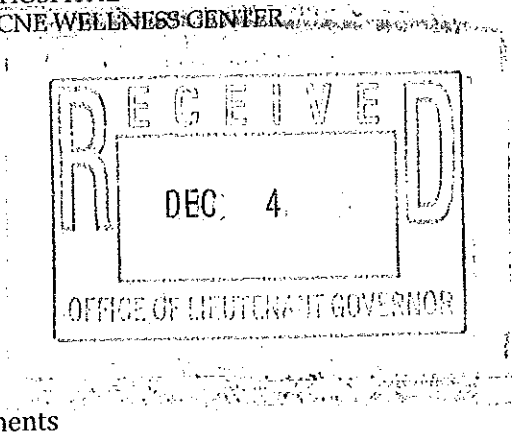

November 26, 2013

The Honorable Elizabeth Roberts
Lieutenant Governor
State of Rhode Island
Room 116
82 Smith Street
Providence, RI 02903

RE: Rhode Island's State Healthcare Innovation Plan Comments

Dear Lieutenant Governor Roberts:

We are grateful to have had the opportunity to participate in Healthy Rhode Island and to provide comment on the draft State Healthcare Innovation Plan (SHIP or Plan). We applaud the work of your office and that of the other state agencies and many stakeholders involved in this Plan's creation.

We believe that participation in the State Innovation Model (SIM) program is a tremendous opportunity for Rhode Island to be inventive and bold in its aim "to achieve measurable improvement in health and productivity of all Rhode Islanders, and achieve better care while decreasing the overall cost of care". Participation in SIM will also support CNE's present development of value based models that promote health, transform care delivery and reduce costs.

We would like to take this opportunity to highlight some of CNE's efforts that may be included in the Plan. CNE is assembling the necessary components to become a certified Medicare accountable care organization (ACO). The recent affiliation with Memorial Hospital (MHRI) will enhance the system's geographic coverage. MHRI's leadership in patient centered medical homes (PCMHs) and internal and family medicine, as well as the partnership with Rhode Island Primary Care Physicians Corporation (RIPCPC), the state's largest IPA; will play an essential role in the CNE integrated delivery system. The affiliation with The Providence Center (TPC) will enable access to all levels of behavioral health care in the CNE system.

CNE has also partnered with Blue Cross Blue Shield of Rhode Island (BCBSRI) to develop innovative delivery and payment models. The five year agreement between CNE and BCBSRI, known as WIN 4 RI, will support progressive arrangements that involve employers and patients in promoting the Triple AIM. The partnership has resulted in roughly twelve proposed initiatives, the first to be implemented will involve a new care management and payment approach for patients who are severely and persistently mentally ill. The next two proposed programs will be an ACO like model for Medicare Advantage and a maternity care global payment pilot. CNE has also worked with BCBSRI in leading the nationally recognized transitions of care work with Healthcentric Advisors.

We recognize that the Plan cannot describe all the activities of stakeholders in the state but would like to underscore some additional examples of our expertise and commitment to healthcare innovation and reform:

- Two individuals from Care New England have been selected to be part of the Centers for Medicare and Medicaid Services' (CMS) Innovation Advisors Program. Chosen were Nancy Roberts, president and chief executive officer of the VNA of Care New England, and Betty Vohr, MD, medical director of the Neonatal Follow-Up Program in the Department of Pediatrics at Women & Infants Hospital and professor of pediatrics at The Warren Alpert Medical School of Brown University.
- CNE has worked closely with the Rhode Island Quality Institute (RIQI) and Current Care to enhance its Center for Medicare & Medicaid Innovation (CMMI) bundled payment program for heart failure and NICU discharge to a medical home.
- CNE has begun to implement Epic as the ambulatory electronic medical record platform to improve integration of CNE-employed and independent physician practices.
- CNE's contract to implement Epic includes an agreement to interface with Current Care.
- CNE is a pioneer sponsor of the Institute of Healthcare Improvement (IHI) work in palliative and end of life care called the Conversation Project.
- Care New England has developed incentives for its employees to enroll in Current Care and has proactively engaged individuals who touch our system toward Current Care enrollment.
- CNE has submitted a CMS Health Care Innovation Round Two application for behavioral health to manage patients with dual-diagnoses.
- CNE has piloted new wellness programs for its employee health plan including significant smoking cessation programs with the Prochaska behavior change research group based at the University of Rhode Island.

We believe the proposed innovations outlined in SHIP are an excellent start. We support the movement toward ACO-like organizations and believe that they offer the best hope for realizing the Triple AIM. CNE welcomes many of the activities described in the Plan especially efforts around health information availability, coordination and access; PCMH expansion, use of community health teams (CHTs) and the development of workforce models. However, we believe the Plan should go even further to advance health transformation in Rhode Island and that we must take this opportunity to do so.

Rather than commenting on every section in the Plan, we have outlined key areas below that we believe would advance true reform.

1. Measures to reduce health care spending must be clearly defined with triggers for rate adjustments should the industry not meet targets.
2. All payers including governmental, providers, the business community and consumers must participate in developing the Plan for meaningful change to occur.

3. Redesign of insured and self-insured products to promote primary care/PCMH arrangements must be incorporated.
4. High deductible plans should be examined as to whether they create appropriate incentives to foster healthcare delivery reform.
5. Patient engagement is crucial to SHIP success; consumer health literacy including education around services, the importance of having a primary care provider and accountability must be incorporated.
6. Behavioral and oral health must not be carved out; inclusion will remove obstacles to effective physical/behavioral health integration.
7. Sub-specialists must be brought in to global risk arrangements and engaged in plans in order to align incentives.
8. There should be a heightened focus on chronic disease management, palliative and end of life care.
9. Rhode Island Care Transformation and Innovation Center (RICTIC) should support the creation of quality and outcome standards based on evidence based medicine and strive for universal application.
10. Opportunities for CNE and other provider systems to connect through Epic should be explored to facilitate involvement in value based plans.
11. Priority must be given to reducing the disparities in care among races, ethnicities and socioeconomic backgrounds; these disparities are mentioned in the application but not prioritized.
12. Plans to care for the undocumented immigrant population should be included in a comprehensive plan.
13. Future opportunities to further centralize some services, such as diabetic education, should be explored once PCMH implementation is to scale in Rhode Island.
14. The development of workforce models should also include a review of incentives and disincentives to practice in Rhode Island which make recruitment a challenge.
15. Financial support is necessary for the accelerated deployment of health information technology including the use of new technologies.

As earlier stated, we support the many existing activities and new interventions outlined in the Plan but recognize that meaningful transformation will only occur if it is truly a collective action. That being said, we are optimistic about the future of healthcare in Rhode Island and our journey toward creating a high performing health care system. We are very grateful for the opportunity to participate in Healthy Rhode Island and wish to convey our enthusiasm for future involvement.

Please feel free to contact me with any questions regarding these comments.
Sincerely,

Dennis D. Keefe

Dennis Keefe
President and Chief Executive Officer

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November 26, 2013

The Honorable Elizabeth Roberts
Lieutenant Governor
State of Rhode Island and Providence Plantations
82 Smith Street, Room 116
Providence, RI 02903

Dear Lt. Governor Roberts:

On behalf of the physician, resident, medical student and Physician Assistant members of the Rhode Island Medical Society I am writing to express our sincere appreciation for your leadership and efforts to reform the health care delivery system in our state. We wish to specifically commend the work of your staff, in particular Deputy Chief of Staff Daniel Meuse, for their tireless work to produce the draft State Healthcare Innovation Plan, SHIP. We are highly encouraged by the extensive stakeholder outreach that has allowed us all to participate in the SHIP design process.

Definitions/terminology

*As we have commented at many of the SIM workgroup meetings, the use of the term Accountable Care Organization, ACO or "ACO-like structures" does not capture the full breath of potential payment models to replace the current fee-for-service model. Nor is it reasonable to think that all physicians will ever be involved in the narrowly defined ACO-like structure. We would suggest mirroring current Medicare related legislation in Congress that uses the more inclusive Alternative Payment Models, (APM) terminology. We should not make the ACO-like structure the only risk bearing payment reform model as we attempt to bend the cost curve.

*Goal 1 on page 36 states that the "primary goal of the SHIP is to transition at least 80% of covered lives in the state into value-based care arrangements." We feel this is an achievable goal as it relates to having those covered lives in a primary care practice that is participating in alternative payment models. However on page 55 under the bullet *Use regulatory and purchasing powers to set contracting standards,* the 80% goal is restated "to require value-based structures for 80% of commercial payments to (all) providers increasing in increments over the next five years." That is a much more difficult and higher standard. One traditional complaint is that the current one-size-fits-all payment system has not provided an affordable or efficient healthcare delivery system. Given that most specialty care is provided in an episodic manner, treating patients from multiple primary care practices, it is very hard to imagine that payment for specialty care could be easily integrated into an ACO-like structure in within the timeframes envisioned. The SHIP draft recognizes that "value-based care is still a relatively young concept. We suggest that the SHIP consistently reflect the covered lives standard.

- "Physician Extenders" is not an appropriate term when discussing the healthcare delivery workforce. As we move through the process of reforming our delivery and payment models to include newer support personnel, e.g. community health workers, we must be mindful that those highly trained professionals such as physician assistants, nurses, social workers, etc. Who provide direct patient care will be functioning in a more "team based" care delivery model. We suggest "advanced practice clinicians" as a more respectful and defining term.

Population health targets:
We agree with most of the targets included in the SHIP draft. In fact, those pertaining to reducing hospital readmissions and ambulatory sensitive emergency room visits are well underway in RI. However, far too many physicians report they often find themselves providing behavioral health services to patients due to the lack of timely and appropriate access to behavioral health services in our state. We include addiction diagnosis in our definition of behavioral health. Because many patients have both physical and behavioral health diagnoses it is imperative that we emphasize improving access and integration of behavioral health in the patient-centered models of primary care.

We would also strongly suggest that increasing access to timely oral health be included in the SHIP.

Rhode Island Care Transformation and Innovation Center, (RICTIC):
Rhode Island is fortunate to have an existing organization that is currently providing many of the resources envisioned in the RICTIC description, Healthcentric Advisors, located at 235 Promenade Street in Providence.

Conduct a workforce assessment:
In order to ensure that Rhode Islanders have sufficient access to the appropriately trained physicians in multiple specialties, from those practicing primary care to specialty care, any workforce assessment must address the complicated issue of adequate distribution of physicians by specialty. We have long experienced difficulty in recruiting and retaining physicians in RI; thus any assessment must consider those factors that have led to this problem.

Behavioral Health:
The quadruple aim of providing the right care, at the right time, in the right place, by the right professional must be applied to the behavioral health issues facing us. There are two overarching issues that we feel must be addressed: full implementation of mental health parity and the payment models of the payers. Many psychiatrists find that they are simply unable to meet the financial needs of operating a small business practice within the current reimbursement models. Co-location strategies are a minimal first step. Access to psychiatric care and an increase in acute care hospital settings are bigger challenges.

Patient Engagement:
The SHIP draft lightly touches upon how patients will interact with the envisioned changes in the healthcare payment and delivery models. One very key component of why our current systems need changing is patient engagement. Patient's lack of understanding of their insurance policy and the structure and interaction of the healthcare delivery system has contributed to the shortcomings of our current systems. In a system where providers will share some level of financial risk with insurers, the patient can be a spoiler. Lack of compliance by a patient will skew data gathering and analyses, health outcomes and ultimately reimbursement.

We look forward to continuing to participate in our state's healthcare reform efforts.

Sincerely,

Elaine C. Jones, MD
President

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Edward J. Quinlan
President

November 21, 2013

The Honorable Elizabeth Roberts
Lt. Governor
State of Rhode Island
Room 116
82 Smith Street
Providence, RI 02903

Dear Lt. Gov. Roberts:

We appreciate the opportunity to provide comments on the recently distributed draft State Health Care Innovation Plan (SHIP). The Hospital Association of Rhode Island (HARI) participated in the planning process in recent months, and looks forward to the next stage. With the Plan still in development, our comments complement and expand the opportunities identified in the draft.

High risk (5%) population
HARI has submitted an application to the Rhode Island Department of Labor and Training (DLT) for a community health worker grant, which will help to further strengthen this emerging workforce. Hospitals also recently completed a statewide community health needs assessment, a process by which they have identified opportunities for continued community alliances.

Hospitals have a strong history of collaboration toward a shared goal of quality improvement, and additional opportunities similar to the Rhode Island ICU Collaborative should be examined.

Rising risk (15%) population
HARI recently launched Rhode Island Health Care Matters (www.rihealthcarematters.org). This partnership with the Rhode Island Department of Health offers data and analytics that will assist in tracking improvement in community health.

With the recent launch of HealthSourceRI, it is important that our State supports health insurance plans that provide a focus on primary care and wellness.

Low risk (80%) population
HARI could participate in public marketing campaigns on health care promotion/education to further introduce hospital community health programs and RI Health Care Matters.

HARI may also provide analytic resources for this population.

Behavioral health
Butler Hospital is committed to aligning mental health with primary care, with other hospitals supporting this initiative. Hospitals have identified mental health and substance abuse as a primary goal following the community health needs assessment. Statewide and community-specific implementation plans to improve behavioral health have been adopted.

Data and analytics
HARI established a Data Center several years ago, which has grown in capacity and recognition. We can significantly assist, participate or lead efforts to comprehensively organize a state data center or consortium. This concept was discussed with The Advisory Board.

Workforce
The HARI Center for Health Professions has pioneered workforce research, analysis, training, and academic coordination for 15 years. We stand prepared to build on that foundation.

Sincerely,

Edward J. Quinlan

Edward J. Quinlan
President